1989

Errol A. Wilstead v. Industrial Commission of the State of Utah, West Way Motor Freight, Liberty Mutual Insurance Company, and Employers Reinsurance Fund : Brief of Appellant

Utah Court of Appeals

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IN THE UTAH COURT OF APPEALS

ERROL A. WILSTEAD, Appellant, v. Industrial Commission of the State of Utah, West Way Motor Freight, Liberty Mutual Insurance Company, and Employers Reinsurance Fund, Respondents.	APPELLANT'S BRIEF PRIORITY CLASSIFICATION: 6 Court of Appeals No. 890456-CA

APPEAL FROM THE ORDER ENTERED BY THE HONORABLE TIMOTHY C. ALLEN, ADMINISTRATIVE LAW JUDGE (ALJ) FOR THE INDUSTRIAL COMMISSION OF THE STATE OF UTAH, PURSUANT TO A HEARING HELD MARCH 16, 1989

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STATEMENT OF JURISDICTION

This Court exercises jurisdiction pursuant to §35-1-86 Utah Code Ann., et seq., (1953) as amended.

SUMMARY OF PROCEEDINGS

This is an appeal from the Findings of Fact, Conclusions of Law and Order entered by the Honorable Timothy C. Allen, Administrative Law Judge (ALJ) for the Industrial Commission of the State of Utah, pursuant to a hearing held before ALJ Allen on March 16, 1989, and the subsequent order of the industrial commission, conducted on June 22, 1989, denying review of the Findings of Fact, Conclusions of Law and Order of the ALJ. In his Findings of Fact, Conclusions of Law, and Order, the administrative law judge concluded that although the appellant had suffered an injury as the result of a slip and fall on October 28, 1989, that he found no evidence that the appellant, based upon his own testimony, had suffered a head injury as the result of the fall. The appellant moved that the conclusions of the administrative law judge be reviewed by the industrial commission, which upheld the findings of the administrative law judge, although commenting that:

> Finally, the commission finds that the medical evidence in this case is conflicting with respect to whether the alleged head injury could possibly cause the applicant's current psychiatric and/or neurological problems. Based upon these considerations, the commission finds that the administrative law judge was correct in determining that no head injury occurred on October 26, 1986.

Order of the Commission denying motion for review, pp. 1-2.

STATEMENT OF ISSUES

1. Did the ALJ abuse his discretion in failing to impanel a Medical Advisory Board, or in failing to provide a Medical Consultant for the Court, in accordance with §35-1-77, Utah Code Ann.?

2. Did the ALJ err in relying upon the testimony of a witness whose competence and credibility were at issue?

3. Did the ALJ err is failing to provide an award for Temporary Partial Disability in keeping with the requirements of §35-1-65.1, Utah Code Ann.?

DETERMINATIVE CONSTITUTIONAL PROVISIONS, STATUTES, ORDINANCES AND RULES

The conduct of and outcome of these proceedings are governed by §35-1, Utah Code Ann., and the Rules of this Court, appropriate selections of which have been reproduced by photocopy for the Court's convenience, as contained in Appendix "A". In particular, the appellant refers this Court to §35-1-77, Utah Code Ann., (1953) et seq., as amended.

STATEMENT OF THE CASE

This is an appeal reviewing the Findings of Fact, Conclusions of Law and Order of Timothy C. Allen, Administrative Law Judge for the Industrial Commission of the State of Utah dated 27 March, 1989, denying the claim of the appellant for an award of compensation under the provisions of §35-1,

Utah Code Ann., and of the Order of the commission denying review of the same.

For the purposes of this appeal, the appellant wishes to make clear the fact that he alleges no new set of facts being argued for the first time on appeal, and that the issues being argued by the appellant are legal in nature, centering upon an alleged abuse of discretion. Therefore, the appellant assumes, arguendo, that the facts operative in this appeal should be taken from three sources, the findings of fact of the ALJ and their review by the industrial commission, the transcript of the hearing, and the medical records involved, all of which taken together constitute the record in this case. The medical records should be considered as underlying the ALJ's decision in this matter, and are fundamental to the findings drawn which are based in no small part upon the testimony of the appellant. On numerous occasions, the ALJ disallowed the testimony of the appellant, stating in effect that the medical records spoke for themselves, or where already in the "file" and needed no substantiation or further explanation. (T. 24, 28, 39, 46, 66)

In the findings of fact, the administrative law judge concluded that there had indeed been a slip and fall on October 26, 1986, involving Mr. Wilstead, while he was acting within the scope of his employment with co-respondent West Way Motor Cargo. The administrative law judge further concluded that there was no injury to appellant's head during the course of the slip and fall. The administrative law judge found that the appellant had sustained a temporary aggravation of a preexisting injury to the lower back, but that he suffered no injury to the brain as a result of a head injury in that slip and fall.

Importantly, the administrative Law Judge did not make any finding relative to the effect that a slip and fall serious enough to re-fracture a vertebrae might have on the human brain. The administrative law judge

simply found that there was no contact between the head of the appellant itself and the pavement, or fuel island curb.

Finally, the appellant invites this court to review the voluminous medical file on record, and note that every single one of the neuropsychologists, and psychiatrists concluded that the appellant was severely depressed, constituting an undisputed fact, and that only one medical provider competent to render conclusions relative to the existence of Organic Brain Syndrome concluded that the appellant was not suffering from Organic Brain Syndrome. The greater weight of the evidence favors the existence of Organic Brain Syndrome, and there is no dispute that the appellant was and is severely depressed.

SUMMARY OF ARGUMENT

The appellant questions the actions of the administrative law judge in entering an arbitrary and capricious finding that appellant suffered no damage to his brain as a result of his slip and fall, without the advice and counsel of a medical review board. The standard of review involving issues of law for administrative proceedings is quite different than the standard regarding findings of fact. The court applies on review the "correction-of-error" standard, giving "no difference to the expertise [or lack of it] of the commission". (Board of Education v. Olsen, 684 P.2d 49 (Utah 1984)) Regarding the role of this court upon review, the standard to be applied is quite liberal in contrast to that applied to findings of fact below.

The administrative law judge proceeded in ruling upon the issue of organic brain damage without the benefit of the expertise of qualified physicians. As Dr. Kotrady states in his report (pages 212 - 213 of the medical records):

> It is my opinion that this man is severely depressed. The depression appears to stem from the industrial accident in October, 1986.
>
> ***
>
> I believe that he [the appellant] is suffering from organic brain syndrome secondary to the accident [at the truck stop]. It is my opinion that he is completely disabled as a result of this condition.

The administrative law judge proceeded in formulating conclusions of law given this sort of declaration by the appellant's physicians without the benefit of a medical review panel. Furthermore, the level of disability from organic brain syndrome is difficult to determine, and the administrative law judge further erred in proceeding in light of the complexity and highly technical nature of the issues at hand:

> It is more difficult in cases of depression due to brain injury to determine the degree of disability than would be the case in the injury of a limb or some other body part. . . I would judge him to be totally disabled in his ability to perform his current line of work -- driving a truck. I also feel that it would be highly unlikely, that in the near term he would be able to obtain and maintain other forms of employment

Dr. Bushnell, at page 161 of the medical reports.

In short, common sense alone or practical experience regarding general medical matters of daily life is wholly insufficient to supply one with the means of addressing the existence of such an injury. Furthermore, the administrative law judge was without competent medical advice as to the effect that organic brain disorder could have on the appellant's ability to testify or

present himself as a credible witness, or even of more fundamental issues, such as the competence of the appellant to testify.

Organic Brian Syndrome, or Organic Mental Syndrome, presents itself in a variety of forms, each with its own symptomatology. Dementia, Alzheimer's Disease, Organic Personality Syndrome, Amnestic Syndrome, Organic Hallucinosis, Organic Affective Disorder and Organic Delusional Syndrome all fall under the general heading or Organic Brain Syndrome. (See appendix "B", attached) Each of these aspects of Organic Brain Syndrome presents itself with different symptoms, which will be discussed in greater detail in appellant's argument proper. Organic Brain Syndrome therefore presents a complex scenario of psychological symptoms, which are difficult to establish and prove, given the fact that in our world of scientific approaches to virtually all human inquiry, we depend almost exclusively upon physical evidence, when in fact some things, such as Organic Brain Syndrome have no physical manifestation that can be perceived clearly given our current standards of investigation. Nevertheless, although it is almost impossible to find physical evidence of Alzheimer's Disease in some patients, spending a few minutes with them readily convinces one that the do in fact have the disease, in spite of the lack of physical evidence. There, the ALJ needed experts to assist the Administrative court in assessing, first of all, the fundamental competence of the appellant as the only witness of the slip and fall, and need experts to advise it as to the ability of the appellant to offer credible, non-contradictory testimony over a given period of time. To conclude that someone diagnosed with Organic Brain Syndrome and severe depression is not a credible witness appears facile and misses fundamental issues relative to the truthfulness or reliability of the facts underlying the ALJ's decision denying an award to the appellant.

Utah Code Annotated §35-1-77, provides for the impaneling of a medical advisory board to assist the administrative judge in the resolution of matters which involve a medical expertise beyond that possessed by the judge. It is important to remember that hearings in these matters are fact finding forums primarily, and that the administrative law judge is to, in essence, conduct an inquiry into the facts surrounding the assertions of the claimant. The ALJ is armed with a battery of statutorily created mechanisms designed to supply discretionary fact-finding ability not found in courts of law. For that reason, greater weight is given to the findings made by the administrative law judge, and on appeal, one must demonstrate that the facts are wholly unsupported by the evidence presented at the hearing. (Kaiser Steel Corporation v. Monfredi, 631 P.2d 888 (Utah 1981)). However, when in the light of difficult issues (such as a claimant who has sustained previous industrial injuries and who now presents himself as a brain injured witness) the ALJ shirks the duty to make a sufficient inquiry and to take advantage of the expertise readily available through fact-finding mechanisms so as to draw reasonable factual findings and legal conclusions, this Court has the opportunity to rectify and remedy such an obvious abuse of statutory discretion in order to meet the ends of justice.

Central and key to the finding of a compensable accident, or the lack thereof, is the establishment of both a legal cause of the injury as well as a medical cause. Certainly the appellant concedes that in cases where the claimant lost a finger or limb while operating industrial equipment at the claimant's place of employment while in the scope of employment, provides both legal and medical cause for establishing a compensable injury. The resolution of such claims is, compared to the issues in the present one, quite simple. However, the appellant made a claim, the complexity of which goes

far beyond the bounds of experience and knowledge of all but experts, in asserting an organic brain damage resultant from the slip and fall. The appellant assert therefore, that the administrative judge committed reversible error in failing to find both a legal and medical cause (or the lack thereof) regarding the appellant's claims, in violation of the standards established by the Supreme Court of Utah:

> [T]he key ingredient of an industrial accident is an unexpected occurrence. That occurrence may be "*either* the cause *or* the result of an injury.
>
> ***
>
> The next step in determining whether an injury is a compensable accident requires analysis of whether the injury arose out of or in the course of employment. . . This factor requires proof of a causal connection between the injury and the working conditions ... [W]e first consider the legal cause of the injury and then its medical cause.
>
> ***
>
> Under the statute as now written, "the commission *may* refer the medical aspects of the case to a medical panel appointed by the commission. . . Although referral to the medical panel is not required by statute, we believe in this case that the findings of that panel would aid the administrative law judge. . . (evidence of causal connection between work related event and the injury may be uncertain or highly technical whereby failure to refer the case may be an abuse of discretion).

Hone v. J.F. Shea Company, 728 p.2d 1008 (Utah 1986) , citations omitted, emphasis in original.

In finding no head injury resultant form the October 1986 slip and fall, the ALJ dodged the issue of medical causation. The appellant did, according to the Findings of Fact, sustain a fall, the force of which was sufficient to re-fracture the L-1 vertebra. There was no medical evidence taken regarding whether or not such a fall could compress the spine in such a manner so as to damage the brain stem, or jar the head sufficiently so as to cause brain injury. In short, although the "records" of the physicians "speak for themselves", they are silent as to whether or not there is, for the purposes of Worker's Compensation, a medical cause for the appellant's claim of brain damage. The records simply do not address the issues of medical causation, which was improperly decided by the ALJ, in accordance with his own common capacity and knowledge of neuropsychology. Furthermore, there records were silent as to the interplay of the injury, which was no doubt quite painful, the previous mental or emotional state of the appellant, the severe depression present following the accident, and the substantial issue of brain damage. The medical record is silent concerning the credibility of the appellant's "flashback", which in light of common sense may seem absurd or incredulous, but in light of brain damage or organic brain syndrome coupled with depression, is in fact quite reasonable. Therefore, although the medical records did speak for themselves on certain issues, there were dead silent on others which were of key importance in resolving the appellant's claim below. The reliance of the ALJ on such information and his failure to impanel a medical review board and engage experts to assist in the fact finding mission of the ALJ and the Industrial Commission is grave error, warranting a re-hearing under the written guidance of this Court, sufficient to preserve traditional notions of justice and equity, for which the Worker's Compensation laws were designed and implemented.

ARGUMENT

POINT I

THE COURTS OF THE INDUSTRIAL COMMISSION ARE FACT-FINDING BODIES WHOSE PRIMARY MISSION IS TO UNCOVER THE TRUTH OF A CLAIM THROUGH A WIDE ARRAY OF STATUTORY MECHANISMS

The mission of the Industrial Commission ("commission") , regarding claims made by worker's for injury awards, is primarily that of facts finding. in this regard, they differ significantly from judicial courts. The administrative courts of the commission are more correctly compared with those of continental Europe, than those of the Anglo-American system. Essentially, they are inquisitorial in nature, with a judge resembling at times a prosecutor, rather than an impartial arbitrator and judge of law alone. Unlike the judicial courts of this State, Administrative Law Judges (ALJ's) of the commission can actively participate, without motion of counsel, to move a case along a particular line of fact-finding. In this sense, they "prosecute" the case on at least a co-equal basis with counsel. In order to provide for such "prosecution", the laws of this State have vested ALJ's with broad discretionary powers not granted to judges in courts of justice. The equitable purposes of the granting of such discretion are important. The State thus allows for the speedy conclusion of Worker's Compensation claims. At times, however, if such discretion is abused, the legal conclusions drawn from such inquiries is not afforded a significant degree of deference on appeal, whereas the findings of underlying fact are.

Examples of the broad discretion discussed are found in Appendix "A". In §35-1-77, Utah Code Ann. , there is a provision for the impaneling of a medical review board, or the hiring of medical consultants to assist the ALJ in

drawing appropriate conclusions for the raw or naked fact gathered into the record. At one time, the impaneling of the board was mandatory, but issues of cost savings prompted the legislature to amend the statute, making it discretionary. §35-1-85.1, Utah Code Ann. Allows the ALJ, on a co-equal basis with counsel to notice and take depositions of any person, in order to facilitate fact-finding. §35-1-91, Utah Code Ann. provides that the ALJ can order an autopsy at its own discretion, without motion from counsel, and without hearing counsel's arguments on the matter. §35-1-94, Utah Code Ann. , allows the ALJ to order the inspection, or to personally inspect, the records of employers involved in the claim dispute. §35-1-98, Utah Code Ann. gives the ALJ discretion to order reports from medical providers, irrespective of those submitted by counsel, or in addition to them. In short, the ALJ has all the powers necessary to conduct discovery as if she or he were counsel. In fact, the ALJ is in reality "super" counsel, since such discovery can be made "ex parte", and without argument, objections or hearings.

In emphasizing the fact-finding role of the commission, the Supreme Court of Utah has stated that the courts of the commission are administrative and ministerial in nature, and are only "clothed" with judicial powers (Palle v. Ind. Comm'n., 81 Utah 372, 18 P.2d 299 (1933)), and that the commission is an administrative body, an "arm of the state", not the product of the judicial branch of government. (Woldberg v. Ind. Comm'n., 74 Utah 309, 279 P.2d 609 (1929)) The fact that such discretionary fact-finding mechanisms is provided by statute is evidence alone that they should be employed whenever situations call for expertise or special knowledge. The failure to do so is the sum and substance of "abuse of discretion".

POINT II

THE PURPOSES OF THE WORKER'S COMPENSATION LAWS HAVE BEEN FRUSTRATED BY THE ACTIONS OF THE ALJ

The purpose of fact-finding by the ALJ is to place responsibility for industrially related accidents upon industry and no upon the State or the individual citizens of the Utah. The Worker's Compensation laws are the product of the industrial revolution, which, as an ever-increasing urbanization unfolded, involved a larger and larger working class, with an increased risk of injury due to more complex methods of production. A policy decision was in effect made when the legislature decided to lay the costs of industry on the shoulders of industry through such laws for appropriate compensation. As stated by the Supreme Court of Utah:

> The purposes which underlie the Workmen's Compensation Act are: to assure o the insured employee and his dependants an income during the period of his total disability and to provide compensation for any resulting permanent disability; to accomplish this by a simple and speedy procedure which eliminates the expense delay, and uncertainty in having to prove negligence on the part of the employer; and to thus require industry to bear the burden of the injuries suffered in it.

Wilstead v. Ind. Comm'n., 407 P.2d 692 (Utah 1965)

The Supreme Court of Utah has stated that:

> We have also repeatedly held that this statute [for Worker's Compensation] would be liberally construed, and if there is any doubt respecting the

right to compensation, it should be resolved in favor of a recovery."

Chandler v. Ind. Comm'n., 55 Utah 213, 184 P.2d 1020 (1919) at 1021. The legislature of this State made the conscious decision to create a commission designed to place the burden of industrial accidents upon the shoulders of industry. In order to accomplish this, the commission has been vested, as an arm of the state itself, with broad discretion in its fact-finding mission.

It appears that the ALJ in the present case is unapprised of the mission and goals of the Worker's Compensation laws of this State. I found that there indeed had been an industrially related accident, involving the re-injury of the claimant's lower back, yet failed to provide compensation, and instead it has forced the claimant , and the citizens of this State, to bear the expense of this accident. Furthermore, the ALJ failed in inquire into the causal links between the obviously powerful fall to the ground, and the alleged brain injury, independent of any injury to the head. In so doing, the costs of the claimant's inability to function as an employable member of the society of this State is born by the claimant and the citizens of Utah. Such is in direct conflict with the purpose of the Worker's Compensation laws.

POINT III

THE APPELLANT IS ENTITLED TO COMPENSATION FOR A TEMPORARY PARTIAL DISABILITY SUFFERED AS THE RESULT OF THE SLIP AND FALL IN OCTOBER OF 1986

In his Conclusions of Law, the ALJ states that he determined that Mr. Wilstead sustained a "temporary aggravation to his low back on October 26th, 1986, while employed by Westway Motor Freight, with no permanent

impairment resulting therefrom." (Findings of Fact, Conclusions of Law and Order, p. 8) §35-1-65.1, Utah Code Ann. provides for an award based upon temporary partial disability resulting from an industrially related accident. The ALJ found that such temporary partial disability had in fact occurred, yet failed to make an award based upon that finding. Such is obvious error, and should result in reversal in order to determine the appropriate amount of the award Mr. Wilstead should receive, or in the alternative, it is appropriate for this Court to make such an award upon review.

POINT IV

THE ALJ ABUSED THE STATUTORY DISCRETION VESTED IN THE INDUSTRIAL COMMISSION IN FAILING TO IMPANEL A MEDICAL ADVISORY BOARD OR HIRE A MEDICAL CONSULTANT TO ASSIST IN RESOLVING ISSUES RELATING TO THE COMPETENCY OF MR. WILSTEAD, THE CREDIBILITY OF HIS TESTIMONY AND THE ISSUE OF MEDICAL CAUSATION OF HIS DEPRESSION AND BRAIN DAMAGE.

The fact that medical providers agreed unanimously that Mr. Wilstead was severely depressed, and that others claimed he was brain damaged, raised serious issues regarding the competency of Mr. Wilstead, his ability to offer credible testimony and the medical causation of the brain damage and depression. This abuse of discretion was not brought to the attention of the ALJ or the commission, but is raised on Mr. Wilstead's petition for review by this Court.

However, in order to understand the implications of raising a matter for the first time on appeal, we should divide factual issues from questions of law, or from the advancement of a particular legal theory at the hearing. Unfortunately, there is little Utah law on the subject of Worker's Compensation compared to that generated by many other states. Therefore,

the appellant cites the following California cases for the benefit of this Court regarding the split between new facts and new theories of law or questions of law on appeal: Muffett v. Royster, 195 Cal.Rptr. 73 (1983); Wilson v. Lewis, 165 Cal.Rptr. 396 (1980).

The Supreme Court of Utah did address this very issue in the case of Stanley v. Ind. Comm'n., 8 P.2d 770 (Utah 1932). The court therein stated at page 771:

> The rule that pertains to the courts to the effect that parties cannot try a case on one theory and then attempt to gain reversal upon some other theory on appeal not advanced on the trial should probably not be applied as strictly to the commission ... The reasons that lie at the base of that rule as applied to the courts are not as potent as applied to the commission. It is its duty to determine whether the conditions precedent exist which entitle an applicant to payment. Consequently it has the duty to determine, regardless of the theories advanced by counsel, whether the condition precedent exists.

The Supreme Court demonstrated its understanding of the purpose of the commission and that its primary function is to determine the appropriateness of an award to the claimant. The hearing before the ALJ was not a true adversarial hearing, and the discretionary powers of the commission, discussed previously, combine to make the strict rule forbidding the advancement of one theory at trial and another on appeal untenable, and subject the applicability of that rule to a case by case testing. It is the raising of new facts for the first time on appeal, which call for the entry of factual findings by the appellate court, which is clearly improper. The appellant has taken steps to assure this Court that it calls for no new or additional factual determination in these proceedings. Instead, Mr. Wilstead contends that the

commission had all of the information necessary to raise the issues of competency, capacity to testify and medical causation of the claimed brain damage before it. The ALJ had the duty to ascertain medical causation, had the duty to employ statutory discovery tools and mechanisms for resolving these issues, and failed to do so. These issues were clearly before the ALJ. It is inconceivable that one could elicit testimony form an individual whom medical providers had concluded was brain damaged, without some question as to competency and capacity surfacing. Furthermore, it is inconceivable that the ALJ was unaware of the issue of medical causation in this case. however, rather than seeking competent and qualified advice and guidance on these subjects, the ALJ proceeded as a lay person.

Under ordinary circumstances, this may not be an abuse of discretion. The nature of ulcers, for example, is a subject that can be understood by most persons with a simple explanation with visual aids. We are not dealing with so simple a subject in this appeal. While the appellant does not call for any factual finding by this Court, Mr. Wilstead points out through counsel the highly technical nature of his claim for brain damage.

As stated by Dr. Richard L. Elliot in his article "An Introduction to Organic Brain Syndromes", Vol. 5, no. 3, Behavioral Sciences and the Law, Su. 1987, at page 287:

> Organic brain syndromes are of forensic interest for several reasons. First, patients with organic brain syndromes may require judicial determination of competence in any number of areas ... Second, any patient whose mental state is of legal interest will need evaluation for contributing organic factors; uncovering these factors may have considerable medical and legal consequence. Third, the discovery of organic factors may be decisive in the

> outcome of a judicial proceeding, where "hard" biological data are often accorded more weight, and are thus more persuasive than "soft" psychological data.

A copy of the article is attached as Appendix "B" for the Court's convenience. Because counsel for the appellant does not wish to be perceived as attempting to argue new facts on appeal, a discussion of the numerous types of Organic Brain Syndromes will not be undertaken in great detail. However, one final quote from Dr. Elliot's article will be sufficient to illustrate the ALJ's undertaking in ruling on medical causation of the appellant's brain damage:

> There are many possible etiologies for each organic brain syndrome. Virtually any medication or physical illness can conceivably lead to an organic brain syndrome. A listing of all the possibilities would be so large as virtually to constitute a table of contents in a textbook of medicine.

Elliot at 288.

Failure to impanel a medical board can be grounds for reversal by this Court. Certainly it is grounds for such a reversal according to facts of this case. The test of whether or not the failure to impanel of a medical board is error was set out in Hone , supra. At page 1011, the Supreme Court states:

> Although referral to the medical panel is not required by statute, we believe in this case that the findings of that panel would aid the administrative law judge. *See Champion Home Builders v. Industrial Commission,* 703 P.2d 306, 308 (Utah 1985) (evidence of causal connection between work-related event and the injury may be uncertain of highly technical whereby failure to refer the case may be an abuse of discretion).

> [Note that Hone also addresses the fact that a claimant is not barred simply by the existence of a pre-existing condition, but that the level of proof required is higher]

Since the very competency and credibility of the only witness to the industrial accident in question was at issue, and medical causation was also at issue, the necessary evidence upon which the ALJ could make any findings whatsoever was uncertain. The issues involved are highly technical as well. The facts of this case bring it within the holding in Hone.

The ALJ, clearly abused his discretion in failing to seek competent and qualified advice on the subject of organic brain disorders. The expansive nature of the subject, together with its highly technical testing procedures requires special counsel and advice to the commission. A copy of some of the organic brain syndrome tests undertaken by the medical providers of the Mr. Wilstead has been attached as Appendix "C". I would invite this Court to examine these test results. They, indeed, speak for themselves, but not in favor of the ALJ's ruling.

CONCLUSIONS

The ALJ erred in filing to at least compensate Mr. Wilstead for a partial temporary disability, and in failing to seek competent and qualified medical counsel by impaneling a medical board. Such requires the vacation of the Order of the commission, and the entry of new findings, pursuant to the written guidance of this Court.

Dated this 8th day of November, 1989.

DAVID D. PECK

MAILING CERTIFICATE

I certify that a true and correct copy of the foregoing **APPELLANT'S BRIEF** was mailed postage prepaid this 8th day of November, 1989 to the following:

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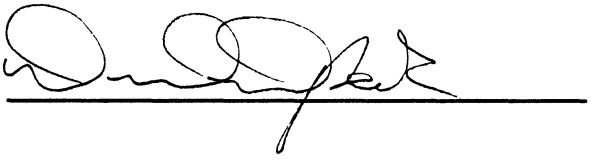

APPENDIX "A"

35-1-10. Rules for procedure.

Subject to the provisions of this title, the commission shall adopt and publish rules and regulations governing procedure before it, and shall prescribe forms of notices and the manner of serving the same in all claims for compensation, and may change the same from time to time in its discretion. Such rules and regulations shall include provisions for procedures in the nature of conferences in order to dispose of cases informally, or to expedite claims adjudication, narrow issues and simplify the methods of proof at hearings.

History: L. 1917, ch. 100, § 9; C.L. 1917, 3069; C.L. 1917, § 3130x, added by L. 1919, ch. 63, § 1; R.S. 1933 & C. 1943, 42-1-10; L. 1965, ch. 67, § 1.

NOTES TO DECISIONS

ANALYSIS

Effect of rules.
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Settlement of claims.
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Effect of rules.

Injured employee who makes application for compensation to commission is bound to take notice of its rules and regulations affecting that application. Varoukas v Industrial Comm'n, 56 Utah 574, 191 P. 1091 (1920)

Effect of violation of rules.

Where employee violates rule of Industrial Commission or disobeys orders of attending physician, or otherwise arbitrarily refuses to cooperate with those in attendance upon him, the award or compensation should cover only such period of incapacity or disability as would usually and ordinarily result from character of injury received by employee. Varoukas v. Industrial Comm n, 56 Utah 574, 191 P 1091 (1920).

Where injured employee leaves locality of his employment in violation of rule of Industrial Commission, burden is on such employee to show why his absence has not prejudiced his employer, or insurance carrier, or state insurance fund, and did not prolong period of his disability. Varoukas v. Industrial Comm'n, 56 Utah 574, 191 P. 1091 (1920).

Filing claim.

Within the time allowed for filing the original claim, an unauthorized filing thereof may be ratified by the person in whose behalf it has been performed, and such ratification in a proper case validates the unauthorized act, and is equivalent to original authority for doing it; but after expiration of time for filing original claim, ratification comes too late. Taslich v. Industrial Comm'n, 71 Utah 33, 262 P. 281 (1928)

Forfeiture of compensation.

Rule which gave Industrial Commission power to forfeit all compensation which accrued to injured employee who had left locality of his employment without any hearing is unreasonable and contrary to spirit of Compensation Act (§ 35-1-1 et seq.). Varoukas v Industrial Comm'n, 56 Utah 574, 191 P. 1091 (1920).

Judicial notice.

Supreme Court will not take judicial notice as to what rules of procedure may have been adopted or prescribed by the industrial commission. Carter v. Industrial Comm n, 76 Utah 520, 290 P. 776 (1930).

Power of commission to promulgate rules.

Industrial Commission has ample power to promulgate all reasonable rules and regulations for protection of those who are injured, and also to protect rights of employer, and that of insurance carrier, and may safeguard state insurance fund. Varoukas v Industrial Comm'n, 56 Utah 574, 191 P. 1091 (1920).

Presumption on appeal.

Where claimant did not assail or question reasonableness or lawfulness of rules of Industrial Commission with reference to compensation claims for hernia, Supreme Court assumed that such rules are reasonable and lawful. Staker v. Industrial Comm'n, 61 Utah 11, 209 P. 880 (1922).

Rules of evidence.

Industrial Commission is not authorized under this section and § 35-1-88 to promulgate rules prescribing what evidence shall be necessary to warrant recovery in particular cases; authority to prescribe particular evidence necessary to establish fact is peculiarly within province of legislature, and involving substantive law, cannot be assumed by commission in absence of express statutory provision delegating such authority. Livingston v. Industrial Comm'n, 68 Utah 567, 251 P. 368 (1926).

Rules of procedure.

The rules promulgated by the commission must be reasonable and must conform to the spirit of the Compensation Act (§ 35-1-1 et seq.). Varoukas v. Industrial Comm n, 56 Utah 574, 191 P. 1091 (1920).

Rules of procedure promulgated by commission cannot deprive parties of constitutional rights to day in court and of having cause determined after impartial hearing. Ocean Accident & Guarantee Corp. v Industrial Comm n, 66 Utah 600, 245 P. 343 (1926).

This section gives the Industrial Commission power to adopt rules of procedure not inconsistent with the act (§ 35-1-1 et seq.). Carter v. Industrial Comm n, 76 Utah 520, 290 P. 776 (1930).

Settlement of claims.

The commission has the prerogative to adopt regulations governing the settlement of claims. Wilburn v. Interstate Elec., 748 P. 2d 582 (Ct. App. 1988).

Written application.

The commission should insist that every applicant comply with its rules by which he is required to file a written application. Such an application should be filed in every case and at least the jurisdictional facts should be stated. Utah Fuel Co. v. Industrial Comm n, 59 Utah 46, 201 P. 1034 (1921)

The application or claim for compensation must be made by the party entitled to compensation, or by or through some other person legally authorized to act for him. A claim made in behalf of a dependent by a mere volunteer binds neither dependent nor employer, and is a nullity. Taslich v. Industrial Comm'n, 71 Utah 33, 262 P. 281 (1927).

A claim for compensation under the Industrial Act (§ 35-1-1 et seq.) is only one claim, no matter how many hearings are had or how many distinct awards are made. It is a claim by the employee for compensation for the injury he has sustained, notwithstanding the compensation may be determined from time to time resulting in many distinct awards. Aetna Life Ins. Co. v. Industrial Comm'n, 73 Utah 366, 274 P. 139 (1929).

COLLATERAL REFERENCES

35-1-19. Investigation of places of employment — Violations of rules or orders — Temporary injunction.

(1) Upon complaint by any person that any employment or place of employment, regardless of the number of persons employed, is not safe or is injurious to the welfare of any employee, the commission shall proceed, with or without notice, to make such investigation as may be necessary to determine the matter complained of. After such investigation, the commission shall enter such order relative thereto as may be necessary to render such employment or place of employment safe and not injurious to the welfare of the employees therein. For any Utah mine subject to the Federal Mine Safety and Health Act, the sole duty of the commission shall be to notify the appropriate federal agency of the complaint. Whenever the commission shall believe that any employment or place of employment is not safe or is injurious to the welfare of any employee, it may, of its own motion, summarily investigate the same, with or without notice, and issue such order as it may deem necessary to render such employment or place of employment safe.

(2) Notwithstanding any other penalty provided in this title, if any employer, after receiving notice, fails or refuses to obey the rules, regulations, or order of the commission relative to the protection of the life, health, safety, or welfare of any employee, the district court of Utah is empowered, upon petition of the commission to issue, ex parte and without bond, a temporary injunction restraining the further operation of the employer's business.

History: L. 1917, ch. 100, § 16, subd. 8; C.L. 1917, § 3076, subd. 8, L. 1921, ch. 67, § 1; R.S. 1933 & C. 1943, 42-1-17, L. 1945, ch. 65, § 1; 1961, ch. 71, § 1, 1988, ch. 198, § 2.

Amendment Notes. — The 1988 amendment, effective April 25, 1988, designated the previously undesignated two paragraphs as Subsections (1) and (2), inserted the third sentence in Subsection (1) and made a series of minor punctuation and stylistic changes throughout the section.

Federal Mine Safety and Health Act. — The Federal Mine Safety and Health Act, referred to in the next-to-last sentence in Subsection (1), appears as 40 U.S.C. §§ 801 to 962.

C.J.S. — 100 C.J.S. Workmen's Compensation § 384

Key Numbers. — Workmen's Compensation ⇐ 1090

35-1-29. Depositions.

The commission or any party may in any investigation cause depositions of witnesses residing within or without the state to be taken as in civil actions.

History: L. 1917, ch. 100, § 21; C.L. 1917, § 3081; R.S. 1933, 42-1-27; L. 1939, ch. 51, § 1; C. 1943, 42-1-27.

Cross-References. — Depositions, Rules of Civil Procedure, Rules 26 to 37.

NOTES TO DECISIONS

Extraterritorial powers.

Commission has no power to hear evidence in another state where such procedure is objected to. McGarry v Industrial Comm n, 64 Utah 592, 232 P 1090, 39 A.L.R. 306 (1925).

COLLATERAL REFERENCES

C.J.S. — 100 C.J.S. Workmen's Compensation § 384.

Key Numbers. — Workers' Compensation ⇐ 1092.

35-1-65.1. Temporary partial disability — Amount of payments.

(1) If the injury causes temporary partial disability for work, the employee shall receive weekly compensation equal to:

(a) 66⅔% of the difference between the employee's average weekly wages before the accident and the weekly wages the employee is able to earn after the accident, but not more than 100% of the state average weekly wage at the time of injury; plus

(b) $5 for a dependent spouse and $5 for each dependent child under the age of 18 years, up to a maximum of four such dependent children, but only up to a total weekly compensation that does not exceed 100% of the state average weekly wage at the time of injury.

(2) The commission may make an award for temporary partial disability for work at any time prior to eight years after the date of the injury to an employee:

(a) whose physical condition resulting from the injury is not finally healed and fixed eight years after the date of injury; and

(b) who files an application for hearing under Section 35-1-99.

(3) The duration of weekly payments may not exceed 312 weeks nor continue more than eight years after the date of the injury. Payments shall terminate when the disability ends or the injured employee dies.

History: C. 1953, 35-1-65.1, enacted by L. 1981, ch. 287, § 2; 1988, ch. 116, § 2.

Amendment Notes. — The 1988 amendment, effective July 1, 1988, designated the previously undesignated first two paragraphs as Subsections (1) and (2); in Subsection (1), divided the formerly undivided language into an introductory paragraph and Paragraphs (a) and (b), rewriting the contents thereof; in Subsection (2), divided the formerly undivided language into an introductory paragraph and Paragraphs (a) and (b), substituted "hearing under § 35-1-99" for "such purpose prior to the expiration of such eight-year period" in Paragraph (b) and, in Paragraph (a), substituted "the injury" for "such injury" and made a minor punctuation change; deleted the former last undesignated paragraph, which read "In no case shall the weekly payments continue after the disability ends or the death of the injured employee"; and added Subsection (3).

35-1-77. Medical panel — Medical director or medical consultants — Discretionary authority of commission to refer case — Findings and reports — Objections to report — Hearing — Expenses.

(1) (a) Upon the filing of a claim for compensation for injury by accident, or for death, arising out of or in the course of employment, and if the employer or its insurance carrier denies liability, the commission may refer the medical aspects of the case to a medical panel appointed by the commission. The panel shall have the qualifications generally applicable to the medical panel under Section 35-2-56

(b) As an alternative method of obtaining an impartial medical evaluation of the medical aspects of a controverted case, the commission in its sole discretion may employ a medical director or medical consultants on a full-time or part-time basis for the purpose of evaluating the medical evidence and advising the commission with respect to its ultimate fact-finding responsibility. If all parties agree to the use of a medical director or medical consultants, they shall be allowed to function in the same manner and under the same procedures as required of a medical panel.

(2) (a) The medical panel, medical director, or medical consultants shall make such study, take such X-rays, and perform such tests, including post-mortem examinations if authorized by the commission, as it may determine to be necessary or desirable.

(b) The medical panel, medical director, or medical consultants shall make a report in writing to the commission in a form prescribed by the commission, and also make such additional findings as the commission may require.

(c) The commission shall promptly distribute full copies of the report to the applicant, the employer, and its insurance carrier by registered mail with return receipt requested. Within 15 days after the report is deposited in the United States post office, the applicant, the employer, or its insurance carrier may file with the commission written objections to the report. If no written objections are filed within that period, the report is considered admitted in evidence.

(d) The commission may base its finding and decision on the report of the panel, medical director, or medical consultants, but is not bound by the report if other substantial conflicting evidence in the case supports a contrary finding.

(e) If objections to the report are filed, the commission may set the case for hearing to determine the facts and issues involved. At the hearing, any party so desiring may request the commission to have the chairman of the medical panel, the medical director, or the medical consultants present at the hearing for examination and cross-examination. For good cause shown, the commission may order other members of the panel, with or without the chairman or the medical director or medical consultants, to be present at the hearing for examination and cross-examination.

(f) The written report of the panel, medical director, or medical consultants may be received as an exhibit at the hearing, but may not be considered as evidence in the case except as far as it is sustained by the testimony admitted.

(g) The expenses of the study and report of the medical panel, medical director, or medical consultants and the expenses of their appearance before the commission shall be paid out of the Employers' Reinsurance Fund.

History: L. 1951, ch. 52, § 1; C. 1943, Supp., 42-1-71.10; L. 1955, ch. 57, § 1; 1969, ch. 86, § 9; 1979, ch. 138, § 6; 1982, ch. 41, § 1; 1988, ch. 116, § 7.

Amendment Notes. — The 1988 amendment, effective July 1, 1988, designated the previously undesignated first sentence as Subsection (1)(a), the previously undesignated second sentence as Subsections (2)(a) and (2)(b), the previously undesignated third and fourth sentences and the beginning of the previously undesignated fifth sentence as Subsection (2)(c), the end of the previously undesignated fifth sentence as Subsection (2)(d), the previously undesignated sixth and seventh sentences as Subsection (2)(e), the previously undesignated eighth sentence as Subsection (2)(f) and the previously undesignated ninth sentence as Subsection (2)(g) The amendment also, in Subsection (1), added Paragraph (b) and, in Paragraph (a), divided the formerly undivided language into two sentences and made a series of minor stylistic changes, in Subsection (2)(a), inserted "medical director, or medical consultants" substituted "to be necessary or desirable" for "and thereafter" and made a series of minor stylistic changes; added "The medical panel, medical director, or medical consultants shall" at the beginning of Subsection (2)(b), in Subsection (2)(c), deleted "of the panel" following "report" in the first sentence, inserted "written" in the last two sentences and made a series of minor stylistic changes throughout the subsection, in Subsection (2)(d), inserted "medical director, or medical consultants", deleted "by the commission" at the end and made a series of minor stylistic changes, in Subsection (2)(e), divided the former first sentence into the present first two sentences, inserted "the medical director, or the medical consultants" in the second sentence and "or the medical director or medical consultants" in the third sentence and made a series of minor stylistic changes throughout the subsection, in Subsection (2)(f) inserted "medical director, or medical consultants" and "at the hearing" and made a series of minor stylistic changes, and rewrote Subsection (2)(g), which read "The expenses of such study and report by the medical panel and of their appearance before the commission shall be paid out of the fund provided by § 35-1-68."

NOTES TO DECISIONS

Analysis

Duty of commission on remand of case.

Where an order of the commission was vacated and the cause remanded because of a deficiency in the evidence to support the report of a medical panel appointed by the commission, the commission was not required to make an award based solely on the plaintiff's evidence; but it was the responsibility of the commission to make some disposition of plaintiff's application for an award and it was the prerogative of the commission to make a determination upon rights; rather, it governs the process under which claims are disposed of by the commission. Moore v American Coal Co., 737 P.2d 989 (Utah 1987).

Function of medical panel.

It is the function of the medical panel to give the commission the benefit of its diagnosis relating to those matters within its expertise, and not to infringe upon commission s responsibility to decide the issues in a workmen s compensation case. IGA Food Fair v. Martin, 584 P.2d 828 (Utah 1978).

Mandatory referral to panel.

This section is mandatory in its requirement that a medical panel shall be convened upon the filing of a claim for compensation for injury by accident, or for death, arising out of or in the course of employment when the employer or insurance carrier denies liability Lupman v Industrial Comm n, 592 P.2d 616 (Utah 1979).

The provision requiring the submission of the medical aspects of the case, including those involving causation, to a medical panel is mandatory Schmidt v Industrial Comm'n, 617 P.2d 693 (Utah 1980).

Objections to report.

Where plaintiff filed written objections to the report of a medical panel which had been appointed by the commission and objected to the report at the hearings, the burden was on the commission or the employer to sustain the report by oral testimony and, where this was not done, the report could not be considered as evidence. Hackford v Industrial Comm'n, 11 Utah 2d 312, 358 P.2d 899 (1961)

Where industrial commission had granted medical expenses from time of claimant's injury to June 13, 1962, and workmen's compensation to and including February 12, 1962, it did not act arbitrarily in denying payments for any later periods, the evidence at the hearing on objections to report of medical panel showing that hospitalization on January 18, 1962, was made necessary by accident in course of claimant's employment causing temporary loss of control of claimant's diabetes; total temporary disability ceased on claimant's return to work initially following accident; there was no permanent disability; and further medical treatment was not needed as the result of the accident. Sanderson v. Industrial Comm'n, 16 Utah 2d 348, 400 P.2d 756 (1965).

Panel report as evidence.

In denying workmen's compensation benefits to claimant, Industrial Commission did not err in considering report of medical panel appointed by commission along with other evidence; medical panel and report did not encroach upon authority vested in commission to make findings of fact and conclusions. Jensen the evidence in the light of the decision of the Supreme Court or to order and hold a supplemental hearing to allow the parties to present additional evidence. Hackford v. Industrial Comm n, 12 Utah 2d 250, 364 P.2d 1091 (1961).

Effect of 1982 amendment.

The 1982 amendment of this section, making the granting of a hearing discretionary, does not enlarge or destroy vested or contractual v United States Fuel Co., 18 Utah 2d 414, 424 P.2d 440 (1967).

In determining that order of commission denying award was supported by sufficient evidence, question whether panel report submitted to commission should be considered as evidence was of no importance where one of panel members appeared and testified before commission, and that testimony alone was sufficient to sustain order of commission. McWilliams v Industrial Comm n, 21 Utah 2d 266, 444 P.2d 513 (1968)

Although great respect must be paid to panel of medical experts appointed pursuant to this section, they are not ultimate finders of fact but rather reporters of medical aspects of given case in aid of Industrial Commission s appraisal and weighing of all facts; therefore, where commission adopted panel's conclusion which was unsupported by any credible or competent evidence, commission s award of benefits was reversed. Redman Warehousing Corp. v Industrial Comm n, 22 Utah 2d 398, 454 P 2d 283 (1969)

Where expert opinion of medical panel that was adopted by the commission was based on incorrect factual foundation assuming no prior history of back pathology, there was insufficient evidence to sustain the award; and when new evidence of prior history was obtained, matter was remanded to commission so that medical panel could reconsider its findings based on the new information. Utah Packers, Inc. v Industrial Comm n, 24 Utah 2d 230, 469 P.2d 500 (1970)

Although all other evidence and testimony indicated that the plaintiff was totally disabled, report of the medical panel that plaintiff had suffered a 50% permanent partial disability is sufficient to support finding of industrial commission of a partial disability Shipley v C & W Contracting Co., 528 P.2d 153 (Utah 1974).

It is the duty of the commission to consider not only the medical panel report, but also all of the other evidence, and to draw whatever inferences and deductions than can be fairly and reasonablya derived therefrom in reaching a decision on the issues. IGA Food Fair v. Martin, 584 P.2d 828 (Utah 1978)

Although medical panel report did not link employee s heart attack with the stress he had experienced four days earlier at his job, the commission's finding that there was a causal connection between the stress and the subsequent heart attack was neither arbitrary or capricious and not without any substantial evidence to support it where a cardiologist testified that there was in fact a causal link between the stress and the heart attack. Pittsburgh Testing Lab. v. Keller, 657 P.2d 1367 (Utah 1983).

Qualifications of panel members.

Statutory requirement that medical panel member specialize in "treatment of the disease" was met where practice consisted of representing businesses and teaching, even though physician did not actually treat patients on an appointment basis. Edwards v. Tillery, 671 P.2d 195 (Utah 1983).

Referral to panel.

—Discretion.

As the evidence of the causal connection between an employee lifting a very heavy beam and the perforation of his ulcer was not uncertain or highly technical, the failure to refer the case to a medical panel was not an abuse of discretion. Champion Home Bldrs. v. Industrial Comm'n, 703 P.2d 306 (Utah 1985).

Report, statements and admissions.

In a proceeding for supplemental award of workmen's compensation for deterioration of condition caused by original injury where the commission had appointed a medical panel to make an independent investigation and report for the guidance of the commission, neither party was bound by any statement or admission made either in the report or in the testimony of the chairman of the panel, a doctor, in support of the report. Mollerup Van Lines v. Adams, 16 Utah 2d 235, 398 P.2d 882 (1965).

In proceeding by widow of deceased oil driller to recover compensation for his death from coronary occlusion on ground that death was caused by inhalation of fumes while mixing mud compound designed to flush out clogged pipes during oil drilling operations, the industrial commission did not have to accept the most probable of three theories advanced as possibilities by the panel. Williams v. Industrial Comm n, 17 Utah 2d 169, 406 P.2d 707 (1965).

Supplemental award.

Supplemental award of workmen s compensation for deterioration of condition caused by original injury was properly granted by the commission where evidence of the medical panel, appointed by the commission, showed that claimant's subsequent injuries had not advanced deterioration of condition resulting from original injury Mollerup Van Lines v Adams, 16 Utah 2d 235, 398 P 2d 882 (1965).

Cited in Hone v J.F Shea Co., 728 P 2d 1008 (Utah 1986); Greyhound Lines v. Wallace, 728 P.2d 1021 (Utah 1986).

COLLATERAL REFERENCES

C.J.S. — 100 C.J.S. Workmen's Compensation § 590.

A.L.R. — Workmen s compensation: use of medical books or treatises as independent evidence, 17 A.L.R.3d 993.

Key Numbers. — Workers' Compensation ⇐ 1694

35-1-85.1. Depositions of witnesses authorized.

The commission or any party to a proceeding under this act may cause depositions of witnesses to be taken as in civil actions.

History: C. 1953, 35-1-85, enacted by L. 1965, ch. 67, § 1.

Meaning of "this act". — See same catchline in notes following § 35-1-46.

35-1-91. Physical examinations.

Any employee claiming the right to receive compensation under this title may be required by the commission, or its medical examiner, to submit himself for medical examination at any time, and from time to time, at a place reasonably convenient for such employee, and such as may be provided by the rules of the commission. If such employee refuses to submit to any such examination, or obstructs the same, his right to have his claim for compensation considered, if his claim is pending before the commission, or to receive any payments for compensation theretofore granted, shall be suspended during the period of such refusal or obstruction.

History: L. 1917, ch. 100, § 91; C.L. 1917, § 3152; L. 1921, ch. 67, § 1; R.S. 1933 & C. 1943, 42-1-85.

NOTES TO DECISIONS

ANALYSIS

Additional compensation.
Duty of employee to submit to operation.
Duty to submit to treatment.
Refusal of medical treatment.

Additional compensation.

Order of Industrial Commission denying additional compensation on ground workman had not become totally and permanently disabled since original finding and award for temporary disability would be affirmed although medical testimony was in conflict since mere failure to recover within six-year period after an accident is not conclusive that injury is permanent and total. Spencer v. Industrial Comm'n, 97 Utah 140, 91 P.2d 439 (1939).

Duty of employee to submit to operation.

When a disability can be prevented or removed by a minor and safe operation, or by safe medical treatment, then it is injured employee's duty to submit thereto, and refusal to do so will defeat his claim for compensation for disability caused thereby. The commission may consider all the facts and circumstances surrounding the refusal in determining whether applicant acted reasonably or unreasonably in refusing to submit to treatment. American Smelting & Ref. Co. v. Industrial Comm'n, 76 Utah 503, 290 P. 770 (1930).

Duty to submit to treatment.

The injured employee must submit to proper treatment, either medical or surgical, when it involves so serious risk or suffering and when it is such as a man of ordinary manly character would undergo for his own good. American Smelting & Ref. Co. v. Industrial Comm'n, 76 Utah 503, 290 P. 770 (1930).

Refusal of medical treatment.

If an injured employee unreasonably refuses to submit to proper medical treatment and as a result thereof his disability or injury is rendered greater or permitted to continue, then such disability or injury as is caused by such unreasonable refusal is attributable to voluntary act of employee and not to the accident. In determining what constitutes a reasonable or an unreasonable refusal to submit to medical treatment, the facts and circumstances of the particular case must be inquired into. American Smelting & Ref. Co. v. Industrial Comm'n, 76 Utah 503, 290 P. 770 (1930).

Refusal of employee to submit to necessary and proper medical treatment for his injury because he is timid and probably oversensitive to pain, constitutes no excuse for his refusal. American Smelting & Ref. Co. v. Industrial Comm'n, 76 Utah 503, 290 P. 770 (1930).

COLLATERAL REFERENCES

C.J.S. — 100 C.J.S. Workmen's Compensation § 484.

Key Numbers. — Workers' Compensation ⇐ 1314.

35-1-92. Autopsy in death cases — Authority of commission — Certified pathologist — Public record — Attending physicians — Penalty for refusal to permit — Liability.

On the filing of a claim for compensation for death within the provisions of this act where, in the opinion of the commission it is necessary to accurately and scientifically ascertain the cause of death, an autopsy may be ordered by a majority of the commission and shall be made by a person designated by the commission. The commission shall determine who shall pay the charge of the certified pathologist making the autopsy. Any person interested may designate a duly licensed physician to attend such autopsy, and the findings of the certified pathologist performing the autopsy shall be filed with the commission and shall be a public record. All proceedings for compensation shall be suspended upon refusal of a claimant or claimants to permit such autopsy when so ordered. Where an autopsy has been performed pursuant to an order of a majority of the commission no cause of action shall lie against any person, firm or corporation for participating in or requesting such autopsy.

History: C. 1943, 42-1-85.10, added by L. 1949, ch. 52, § 2; L. 1975, ch. 64, § 4.

Meaning of "this act". — See same catchline in notes following § 35-1-46.

COLLATERAL REFERENCES

C.J.S. — 100 C.J.S. Workmen's Compensation § 485.

Key Numbers. — Workers' Compensation ⇐ 1315.

35-1-94. Employer's records subject to examination — Penalty.

All books, records, and payrolls of an employer showing, or reflecting in any way upon, the amount of his wage expenditure shall always be open for inspection by the commission, or any of its auditors, inspectors, or assistants, for the purpose of ascertaining the correctness of the wage expenditure, the number of individuals employed, and such other information as may be necessary for the uses and purposes of the commission in its administration of the law. If an employer refuses to submit any books, records, or payrolls for inspection, after being presented with written authority from the commission, he is liable for a penalty of $100 for each offense. This penalty shall be collected by a civil action and paid into the Injury Fund administered by the Workers' Compensation Fund.

History: L. 1917, ch. 100, § 92; C.L. 1917, § 3153; R.S. 1933 & C. 1943, 42-1-87; L. 1977, ch. 151, § 8; 1988, ch. 56, § 1.

Amendment Notes. — The 1988 amendment, effective July 1, 1988, divided the former second sentence into the present last two sentences, rewriting the contents thereof, and made a series of minor stylistic changes throughout the first sentence.

Cross-References. — Injury Fund, § 35-3-2.

COLLATERAL REFERENCES

C.J.S. — 100 C.J.S. Workmen's Compensation § 384

Key Numbers. — Workers' Compensation ⇐ 1090.

35-1-98. Control of physicians.

All physicians and surgeons attending injured employees shall comply with all of the rules and regulations, including the schedule of fees for their services, adopted by the commission, and shall make reports to the commission at any and all times as required by it as to the condition or treatment of any injured employee, or as to any other matters concerning cases in which they are employed. A copy of the first report shall be mailed to the injured employee. Any physician or surgeon who refuses or neglects to make any report required by this section is guilty of a misdemeanor and shall be punished by a fine of not more than $500 for such offense.

History: L. 1917, ch. 100, § 95; C.L. 1917, § 3156; L. 1919, ch. 63, § 1; R.S. 1933, 42-1-91; L. 1939, ch. 51, § 1; C. 1943, 42-1-91; L. 1967, ch. 66, § 2.

NOTES TO DECISIONS

ANALYSIS

Admissibility of testimony.
Form of report.

Admissibility of testimony.

Where company doctor's testimony was based upon report by X-ray specialist to company doctor as to what, in his opinion, applicant was suffering from, such testimony was admitted as an exception to the hearsay rule. Uta-Carbon Coal Co. v. Industrial Comm'n, 104 Utah 567, 140 P.2d 649 (1943).

Form of report.

The attending physician makes his report on a printed blank furnished for that purpose in which he describes the injury. Utah Delaware Mining Co. v. Industrial Comm'n, 76 Utah 187, 289 P. 94 (1930).

COLLATERAL REFERENCES

C.J.S. — 99 C.J.S. Workmen's Compensation § 266.

Key Numbers. — Workers' Compensation ⇨ 979.

APPENDIX "B"

Behavioral & Sciences & the Law

NEUROSCIENCES AND THE LAW

SPECIAL PERSPECTIVE

RESEARCH REPORT

An Introduction to Organic Brain Syndromes

Richard L. Elliott, M.D., Ph.D.

Organic brain syndromes are of forensic interest for several reasons. First, patients with organic brain syndromes may require judicial determination of competence in any of a number of areas, e.g., testamentary capacity, need for financial guardianship, or competence to make medical decisions. Second, any patient whose mental state is of legal interest will need evaluation for contributing organic factors; uncovering these factors may have considerable medical and legal consequence. Third, the discovery of organic factors may be decisive in the outcome of a judicial proceeding, where "hard" biological data are often accorded more weight, and are thus more persuasive, than "soft" psychological data. This article provides an introductory overview of the organic brain syndromes. For each syndrome, the clinical features are described and are illustrated with a case vignette, the more common etiologies are presented, and selected aspects to the evaluation are highlighted. In addition, since the detection of malingered mental illness is a key component in many forensic contexts, characteristics are described which help to distinguish actual from malingered mental illness.

INTRODUCTION

Examples in which patients with organic brain syndromes impinge upon the legal system are numerous. Civil issues of testamentary capacity, need for guardianship, and competence to accept or refuse medical treatment arise not infrequently with these patients. In the area of criminal law, evaluations for criminal responsibility and fitness to stand trial very often need to consider the possibility of an organic brain syndrome. Personal injury cases involving possible injury to the brain represent still another arena in which evaluation for the presence of an organic brain syndrome is important.

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This review is written in order to provide an introduction to organic brain syndromes. Each of the organic brain syndromes recognized in the Diagnostic and Statistical Manual, third edition (DSM-III)(American Psychiatric Association, 1980), is discussed with respect to diagnosis, clinical features, and etiologies. Emphasis is placed on those parts of the evaluation that are most pertinent to a forensic setting. Case vignettes illustrate common examples of the ways in which organic brain syndromes may present forensically.

Before considering the individual organic brain syndromes, a few general remarks may be helpful. First, the words "organic" and "brain" convey the idea that these mental disorders are thought to be caused by physical (organic) processes affecting the brain. This distinguishes them from the so called "functional" disorders such as schizophrenia and the affective (mood) disorders, in which a psychological explanation is thought to provide a better basis for the cause of the illness. Although this distinction between organic and functional disorders is time honored, a broader, biopsychosocial view of each illness which considers biological, psychological, and social factors is necessary for a complete understanding. For the organic brain syndromes, this means that the psychological and social aspects of the illness must not be neglected. For example, a patient with dementia, an organic brain syndrome, may have a profound psychological reaction to the illness and become depressed in addition to demented.

A second preliminary comment concerns the distinction between organic brain syndromes and organic mental disorders. An organic brain syndrome is a collection of psychiatric signs and symptoms whose etiology is thought to be organic, but is not specified. Thus dementia is an organic brain syndrome. An organic mental disorder is an organic brain syndrome whose etiology is known or presumed. The organic brain syndrome dementia, which is thought to be due to progressive degenerative dementia (Alzheimer's Disease), is an organic mental disorder.

There are many possible organic etiologies for each organic brain syndrome. Virtually any medication or physical illness can conceivably lead to an organic brain syndrome. A listing of all the possibilities for any organic brain syndrome would be so large as virtually to constitute a table of contents in a textbook of medicine. Therefore, only the more common etiologies will be included in the following discussion.

Since many of the same etiologies can lead to different organic brain syndromes, e.g., head trauma can cause an organic personality syndrome, dementia, or an amnestic syndrome, parts of the evaluation, including history taking, physical examination, and laboratory testing will be common to the various syndromes. In order to forego listing these for each separate evaluation, this basic evaluation for organic brain syndromes is listed in Table I (see, for example, Wells, 1985). Under the individual organic brain syndromes, only the special features of the particular evaluation will be noted.

TABLE I Evaluation of Organic Brain Syndromes

History:	illnesses, medications, alcoholism, head trauma
Examination:	physical, neurologic and mental status examinations
Laboratory:	CT scan or Magnetic Resonance Imaging of the head, chest x-ray, complete blood count, chemistry survey, urinalysis, toxicologic screening, vitamin B12 and folic acid levels, serology for syphilis

Neuropsychological testing is an important part of the evaluation for most organic brain syndromes. It consists of a battery of tests administered by a qualified neuropsychologist, preferably one with forensic experience. The tests help to localize lesions within the brain, ascertain the extent of organic deficits, and determine character traits which are important to the psychological understanding of the individual. Furthermore, and some times more importantly, some of the neuropsychological tests help to determine when an individual is feigning, exaggerating, or denying psychological symptoms. Wasyliw and Golden (1985) have provided a review of forensic neuropsychological testing.

DEMENTIA

Dementia is the most common of the organic brain syndromes, affecting five percent of adults over age 65 severely and another 10% to a moderate degree (Blazer, 1983). Synonyms for dementia include chronic organic brain syndrome and, because of its association with increasing age, "senility." The hallmark of dementia is global deterioration in intellectual ability affecting more than one area of performance. Deterioration is an important component to the definition of dementia, as it distinguishes dementia from syndromes in which impaired intellectual ability is present from birth. In addition, the impairment must be severe enough to cause difficulties in social or occupational functioning. The presence of findings on a mental status examination, in the absence of social or occupation dysfunction, is not sufficient to make a diagnosis of dementia.

The current diagnostic criteria according to DSM-III are shown in Table II.

Memory impairment is a hallmark of dementia and usually consists of difficulties with either short-term (minutes) or recent (days or weeks) memory. Remote (many years) memory is often relatively preserved. Short-term memory is tested by asking the patient to remember the names of several unrelated objects. After a period of several minutes, the patient is asked to recall the objects. Most people can recall two or three objects after several minutes. Alternatively, the patient can be told a short story, which, after several minutes, he is asked to retell. Recent memory is tested by asking the patient about events which have taken place hours or days prior to the examination.

A. A loss of intellectual abilities of sufficient severity to interfere with social or occupational functioning.
B. Memory impairment.
C. At least one of the following:
   (1) impairment of abstract thinking, as manifested by concrete interpretation of proverbs, inability to find similarities and differences between related words, difficulty in defining words and concepts, and other similar tasks.
   (2) impaired judgment
   (3) other disturbances of higher cortical function, such as aphasia (disorder of language due to brain dysfunction), apraxia (inability to carry out motor activities despite intact comprehension and motor function), agnosia (failure to recognize or identify objects despite intact sensory function), "constructional difficulty" (e.g., inability to copy three-dimensional figures, assemble blocks or arrange sticks in specific designs)
   (4) personality change, i.e., alteration or accentuation of premorbid traits
D. State of consciousness not clouded (i.e., does not meet the criteria for delirium or intoxication, although these may be superimposed).
E. Either (1) or (2):
   (1) evidence from the history, physical examination, or laboratory tests, of a specific organic factor that is judged to be etiologically related to the disturbance
   (2) in the absence of such evidence, an organic factor necessary for the development of the syndrome can be presumed if conditions other than organic mental disorders have been reasonably excluded and if the behavioral change represents cognitive impairment in a variety of areas.

This should be information which can be verified, such as meals, visitors, medical tests, or current events. More precise testing of memory functioning is done with the aid of neuropsychological testing.

The capacity to think in an abstract manner is tested by asking the patient to interpret proverbs, taking into account the patients' previous intellectual and educational background. A patient who interprets the proverb "what does ‹still waters run deep› mean?" as "nothing changed, they are still waters," is responding in a concrete and not abstract manner. Other disorders in which concrete thinking is evident include schizophrenia and mental retardation.

Judgment is the capacity for solving personal and social problems. Someone who makes inappropriate sexual comments to a stranger, or makes a will leaving the estate to a stranger, is generally thought to be showing impaired judgment. Since most legal difficulties arise from a patients' impaired judgment, it is important to evaluate the patients' capacity in this area. This is generally done by determining the patients' actual responses to events in his life. Examples of impaired judgment include dressing inappropriately and wandering about carrying large sums of money. Occasionally a hypothetical situation might be presented to a patient such as asking him to state what he would do if he discovered a fire in a crowded movie theater.

Personality changes are common in dementia, with paranoia being the most common. Because of their forgetfulness, patients may forget where they put a particular object. After having lost a number of objects, a patient might begin to believe that someone has been stealing them. It is easier for some patients to accept the idea that objects are being stolen, rather than to acknowledge their failing memory. Other delusions may arise as the patient attempts to explain the disorder and confusion he or she is experiencing.

Other disturbances in functioning are common in dementia. The patient may have an apraxia, that it, a difficulty carrying out motor tasks despite intact muscle strength and coordination. An example of a patient with an apraxia is a women I saw who was accusing her landlord of stealing her keys and replacing them with others that did not fit. When I asked her to demonstrate the "wrong key" she attempted to put the key in the door upside down, and even after multiple attempts, was unable to recognize that simply reversing the key would have worked. Another common disturbance in dementia is aphasia, a difficulty with written and spoken language. Patients may have difficulties finding words for common objects and become considerably frustrated when they are unable to express themselves.

The course of dementia varies greatly with the etiology. The onset may be insidiously slow as in Progressive degenerative dementia (Alzheimer's Disease), or sudden, following head trauma or severe sustained lack of oxygen to the brain. Once established, the dementia may be relatively stable, such as that following anoxia, slowly progressive over a number of years as in Alzheimer's Disease, or rapidly progressive over several months to several years as in a dementia due to an infectious etiology such as Jacob-Creutzfeld's disease.

Dementia has many possible causes, but by far the most common, accounting for about 50% of all dementias, is Progressive degenerative dementia (Alzheimer's Disease). Its onset is typically in the seventh or eighth decade but occasionally appears in younger or older individuals. As noted above, it usually begins gradually, with mild memory loss or subtle personality changes frequently marking the onset of the disease. The early memory changes are often minimized by the patient, who may explain them as "anyone can forget once in a while," or "my memory has never been very good." The personality changes may be as subtle as an increase in irritability or depression. Another early sign of Alzheimer's Disease is an increase in difficulty adjusting to new situations. An employee who has performed well for a number of years may have increasing difficulty solving commonplace problems, and may be unable to adapt to changes at home or work. This can be enormously frustrating and may lead to potentially violent outbursts in a normally docile person.

Changes in personal care are often noted in the early stages of dementia. Personal cleanliness and grooming may suffer, offensive habits may appear, and there may be a deterioration of housekeeping.

The later stages of Alzheimer's Disease are marked by further deterioration in memory, personality, self-care, and judgment. In the final stages, the patient may be bedridden, lose control of bladder and bowel and speak unintelligibly.

The etiology of Alzheimer's Disease is unknown. There is an increased risk of Alzheimer's Disease in the children of an affected parent, but genetic factors play a role in a minority of patients. Attempts to identify an environmental or infectious agent have been intriguing though inconclusive (Mozar, 1987).

Other common causes of dementia include multiinfarct dementia (due to multiple small strokes), normal pressure hydrocephalus, dementia secondary to chronic alcoholism, vitamin deficiency, hypothyroidism or hyperthyroidism, tertiary syphilis, head trauma, brain tumor, or other intracranial masses. Some medications have produced a clinical picture of dementia e.g., anticholinergics, analgesics, antihypertensives, cimetidine, lithium, disulfiram, and digitalis. These and other causes of dementia are discussed more comprehensively elsewhere (Wells, 1977).

A final "cause" of dementia is depression, which leads to a pseudo-demented state which may mimic that of dementia. Depression can lead to difficulties with memory and concentration, changes in personality, and deterioration in personal care. However, these changes in depression are due to a lack of interest or effort, rather than a lack of ability. Improving the patient's effort either with pharmacotherapy or psychotherapy, results in a lifting of the depression and the disappearance of "dementia" (Wells, 1979).

Evaluation of a suspected dementia consists primarily of the items listed in Table I. The focus of the evaluation is the search for potentially treatable causes of dementia; approximately 15% of dementias are completely or partially reversible (Popkin & MacKenzie, 1985). Historical information of particular importance includes a history of head trauma, use of medications, thyroid disease, or syphilis. A complete physical and neurological evaluation is necessary. Laboratory tests should include all of those listed in Table I, with particular emphasis on a brain scan, either via computed tomography or magnetic resonance imaging, thyroid function tests, a urine drug screen, and a test for syphilis. Tests not included in Table I which might be pursued include screening for heavy metals, an electroencephalogram (EEG) and a lumbar puncture.

Case One

> The points contested in this case were four codicils to the will of an old gentleman, on the grounds that at the time of taking them he was incapable by reason of mental decay of understanding their nature and effect. It was testified...that during the two or three years within which the codicils were made he frequently *did not know people with whom he had previously been well acquainted*, without being told who they were; that he would go about the house and garden looking around and *appearing not to know what he was about*. On one occasion he not only did not recognize a certain person but could not be made to understand who he was, and it was testified by a very different kind of witness that the deceased asked him how old was the witness's father (though he had been dead 16 years and had been his partner in business), and soon after he inquired of the witness after his health as if he were addressing another person. Several similar *lapses in memory* and various *appearances of childishness in his conduct* were also revealed by the evidence amply sufficient no doubt to induce superficial observers to believe that he was mentally incapacitated from disposing of property. It appeared, however, that he was in the habit of giving in favor of his brother's butler, drafts accurately signed and filled up; that at Christmas time he gave the servants Christmas boxes and the usual amount of money, and entered the sums in his account book; that he received a farmer's bills for corn and paid them with drafts on his banker which he wrote himself, going through the whole business correctly and that he docketed the bills and receipts on the back with the name of the person to whom paid, and the amount of the bill making corresponding entries also in his private account book; that he signed 20 drafts at least one morning for payment of his brother's debts without instruction or assistance, subscribing his own name as executor of his brother; that we would detect errors in the casting up of other people's account; that he discharged his physician's bills correctly; and in short that he managed his affairs and that prudently and correctly, to the last. It was also testified that it was his practice to read aloud to the family the psalms and lessons of the day; that he was fond of a little fun and played at whist remarkably well. That a person might have done all of this and yet been unsound in mind, is certainly not impossible; but it was far beyond the power of mind so broken up by old age and the invasion of disease as to being capable of altering testamentary deposition previously made. This consideration and the fact that the circumstances of the case furnish abundant reasons for the alteration, induced court to decide in favor of the capacity of the testator.

This case, taken from Isaac Ray's seminal *Treatise on the Medical Jurisprudence of Insanity* (Ray, 1902) illustrates a common forensic problem in which dementia is a consideration, testamentary capacity. This case further illustrates that while the subject may have had some impairment in his memory, orientation, and "childishness in his conduct," there was abundant evidence that he had not lost the capacity to make sound financial decisions. Thus, a finding of the presence of dementia in this patient was not sufficient to demonstrate lack of testamentary capacity. Some areas of intellectual performance, especially in the early stages of dementia, are relatively spared.

Whereas dementia ultimately involves generalized deterioration in multiple areas of functioning there are other organic brain syndromes which involve changes in relatively circumscribed aspects. These syndromes comprise the next section of the article, and include organic personality syndrome, amnestic syndrome, organic hallucinosis, and organic delusional syndrome. In some

TABLE III Diagnostic Criteria for Organic Personality Syndrome

A. A marked change in behavior or personality involving at least one of the following: 1) emotional lability, e.g., explosive temper outbursts, sudden crying; 2) impairment in impulse control, e.g., poor social judgment, sexual indiscretions, shop lifting; 3) marked apathy and indifference, e.g., no interest in usual hobbies; 4) suspiciousness or paranoid ideation.
B. No clouding of consciousness as in delirium; no significant loss of intellectual abilities, as in dementia; no predominant disturbance of mood, as in organic affective syndrome; no predominant delusions or hallucinations as in organic delusional syndrome or organic hallucinosis.
C. Evidence from the history, physical examination, or laboratory test of a specific organic factor that is judged to be etiologically related to the disturbance.
D. This diagnosis is not given to a child or adolescent, if the clinical picture is limited to the features that characterize attention deficit disorder.

cases, these syndromes are relatively stable over time; in others they represent early stages of dementia, and progressively worsen.

ORGANIC PERSONALITY SYNDROME

The essential feature of this syndrome is a change in personality due to organic factors, but not due to another organic brain syndrome such as dementia. The DSM-III diagnostic criteria are shown in Table III.

Case Two

> Phineas Gage was a strong, healthy and popular foreman of a railroad excavation crew. While working at a site, an explosion drove an iron bar into the left side of his face, existing through the top of the skull. He quickly regained consciousness and was treated by a physician. Remarkably enough, there was no residual impairment except for dramatic personality changes. He was described by his physician as "fitful, irreverent, indulging at times in the grossest profanity (which was not previously his custom), manifesting but little deference to his fellows, impatient of restraint or advice when it conflicts with his desires, at time pertinatiously obstinate yet capricious and vacillating, devising many plans for future operation which no sooner are arranged than they are abandoned in turn for others appearing more feasible. His mind was radically changed so that his friends and acquaintances said he was no longer Gage." (Harlow, 1868).

The type of personality changes seen in this disorder are primarily related to the location of damage to the brain. For example, damage to the frontal lobes may result in "pseudopsychopathic" personality changes. A hard working, law

TABLE IV Diagnostic Criteria for Intermittent Explosive Disorder

A. Several discrete episodes of loss of control of aggressive impulses resulting in serious assault or destruction of property.
B. Behavior that is grossly out of proportion to any precipitating psychosocial stressor.
C. Absence of signs and generalized impulsivity or aggressiveness between episodes.
D. Not due to schizophrenia, antisocial personality disorder or conduct disorder.

abiding citizen such as Phineas Gage might become belligerent, impulsive, sexually indiscreet, and may come to the attention of authorities as the result of antisocial behavior. Damage to another part of the frontal lobes may lead to an apathetic, indifferent depressed appearance. In some patients with damage to the temporal lobes, there is a tendency to humorless verbosity in speech and an increase in religiosity and aggressiveness.

A change in the organic personality syndrome proposed for the revised edition of DSM-III, to be published in 1987, is the inclusion of intermittent explosive disorder. The diagnostic criteria for intermittent explosive disorder are shown in Table IV.

In DSM-III, intermittent explosive disorder is listed as a disorder of impulse control. This classification, however, does not take into account experimental data supporting the hypothesis that the disorder results from an irritable electrical focus in the limbic system. The limbic system, which lies deep within the brain, is responsible for some of our most basic responses such as a fight or flight response to danger, feeding, and sexuality. Stimulation of parts of the limbic system have been shown to produce rage attacks in susceptible individuals. In some patient with intermittent explosive disorder, electrodes have been planted deep within the brain to record stimuli in the limbic system. In these patients, an irritable focus was found which seemed to trigger the explosive episodes. Aside from the diagnostic criteria in Table IV, clinical indicators suggesting an intermittent explosive disorder include a history of physical assaults, especially wife and child beatings; pathological intoxication; a history of impulsive sexual behavior, at times including sexual assaults; and a history of many traffic violations and automobile accidents. (Mark & Ervin, 1970)

This diagnosis is particularly appealing to defense attorneys. Its use has been advocated in insanity evaluations to explain impulsive violent behavior (Ratner, 1979). However, before making the diagnosis, the clinician should consider whether a particular violent act was part of a general pattern of impulsive antisocial behavior, or whether it truly represented a relatively isolated explosive episode in the life of a normally peaceful person.

Some of the more common causes of organic personality syndrome include damage to the frontal or temporal lobes secondary to head trauma or tumor; temporal lobe epilepsy (complex partial or psychomotor seizures); metabolic derangements such as hypoglycemia, hypo- or hypercalcemia or hyponatremia; and Huntington's disease.

In addition to the evaluation outlined in Table I, for intermittent explosive disorder an electroencephalogram (EEG) is often useful, particularly with respect to the need for anticonvulsant treatment. Neuropsychological testing may help to document the presence of dysfunctional personality traits and is useful in ruling out the presence of other signs of organic brain disease. Perhaps the most important part of the evaluation is collateral information from sources such as families, employers, teachers, and the military in order to document pre-existing personality traits. It is not the existence of pathological personality traits *per se* which indicate this organic brain syndrome; rather, it is a documented change in personality which is necessary to make the diagnosis.

AMNESTIC SYNDROME

For an accurate memory to be created, an event must be perceived accurately. An event is detected by sensory organs, registered as such in the cerebral cortex, preserved for at least several minutes as a short-term memory, and retained as a long-term memory. In addition, the presence of a memory can not be detected unless memory recall is intact. When these processes are disrupted, the result is anterograde or retrograde amnesia. Anterograde amnesia is a deficit in the ability to learn new material. Its presence is tested for by giving the patient several words or a short paragraph to remember and asking him to recall it after several minutes. Retrograde amnesia, an inability to recall previously learned material, is tested by asking the patient to recall events from his life, and to recall previously learned historical events such as the names of presidents. Overlearned material, such as one's birth place, is relatively resistant to amnesia and is not a sensitive test for the presence of amnestic syndrome.

Organic causes of amnesia usually indicate damage to structures lying within or near the limbic system, the major structures being the hippocampus, fornix, medullary bodies, and parts of the thalamus. The most common causes of amnesia in a nonintoxicated individual is brain damage due to the effects of chronic alcoholism and thiamine deficiency, i.e., Korsakoff's syndrome. In this syndrome, there is a devastating effect on anterograde memory, with relative preservation of retrograde memory. Thus the patient is able to perceive and register information (he is alert and is able to repeat a series of digits), but, after several minutes, he is no longer able to remember it. Because of difficulties forming new memory, the patient becomes disoriented when placed in new surroundings, e.g., a jail or hospital.

Diagnostic criteria for the Amnestic Syndrome are give in Table V. Although not part of these criteria, an interesting clinical feature, particularly in the early stages, is the presence of confabulation. Confabulation is the creation of stories, sometimes fantastic, to fill in the gaps in the patient's memory. I once asked a hospitalized patient with Korsakoff's syndrome what he had eaten for dinner the night before. He responded that he had gone to a "meeting

TABLE V Diagnostic Criteria for Amnestic Syndrome

A. Both short-term memory impairment (inability to learn new information) and long-term memory impairment (inability to remember information that was known in the past) are the predominant clinical features.
B. No clouding of consciousness, as in delirium and intoxication, or general loss of major intellectual abilities, as in dementia.
C. Evidence from the history, physical examination, or laboratory tests of a specific organic factor that is judged to be etiologically related to the disturbance.

of the Polish Falcon Club for a pig fry." It is important to realize that the patient is unaware that what he is saying is false. This distinguishes confabulation from lying, which is done intentionally in order to deceive.

In addition to the effects of chronic alcoholism and thiamine deficiency, other causes of amnestic syndrome include head trauma, herpes simplex encephalitis, transient global amnesia, other vitamin deficiencies, and amnesia following surgery or electroconvulsive therapy (Benson & Blumer, 1982). Amnestic syndrome due to head trauma is often forensically important, and is predominantly anterograde amnesia, so that memory is lost for events which occurred following the injury. In addition there may be a mild retrograde amnesia for events occurring prior to the injury which tends to improve with time.

The most common manner in which amnesia becomes a forensic issue is during an evaluation for criminal responsibility or fitness to stand trial. In these contexts, the examiner must decide whether the amnesia, usually retrograde for the events in question, is the result of organic causes, is pyschogenic, or is the result of malingering. Amnesia due to organic causes is differentiated from psychogenic amnesia and malingering by the factors shown in Table VI. Outside of a forensic setting, secondary gain is most prominent in feigned (malingered) amnesia, is often present in psychogenic amnesia, but is relatively uncommon in organic amnesia. However, in a forensic setting, secondary gain may be prominent in all three conditions. During a sodium Amytal interview, during which the barbiturate sodium amobarbital is administered intravenously, the patient with organic amnesia will often experience a worsening of his amnesia. The memory of a patient with psychogenic amnesia is often improved during an Amytal interview. Patients with feigned amnesia may not reveal their true intention during a sodium Amytal interview. In organic amnesia, there is loss of information relating to personal as well as nonpersonal events. In psychogenic amnesia lost memories are of events of a personal nature. Persons feigning amnesia will often claim to have forgotten all events, personal and nonpersonal. New learning is often impaired in organic amnesia, particularly in illnesses such as thiamine deficiency and chronic alcoholism. New learning is usually not impaired in amnesia due to head trauma or transient global amnesia. In psychogenic amnesia and feigned amnesia, new learning is usually unimpaired. Confabulation may be

Differentiating Organic, Psychogenic and Feigned Amnesia

	Organic Amnesia	Psychogenic Amnesia	Feigned Amnesia
Etiology	Organic	Emotional	Simulated
Secondary Gain	Uncommon	Often	Always
Recovery	Spotty	Full	Full
Response to sodium Amytal	Worsening	Often improved	May or may not improve
Personal versus nonpersonal memory loss	Both	Personal	Both
New Learning	Often impaired	Unimpaired	Unimpaired
Confabulation	In early stages	Uncommon	Uncommon

present in early stages of organic amnesia, but is usually not present in either psychogenic or feigned amnesia.

The most important aspects of the evaluation of the amnesic patient are shown in Table I. Of these, neuropsychological testing is often the most useful, as it can document the presence of both kinds of amnesia anterograde and retrograde, and maybe helpful in detecting the malingering patient. Furthermore, neuropsychological testing may help to document the presence of more widespread intellectual deficits, since it is not uncommon for the demented patient to present first with symptoms of amnesia.

ORGANIC HALLUCINOSIS

Hallucinations refer to the perception of a sensation in the absence of an external stimulus. Hallucinations may occur in any of the five senses: auditory, visual, tactile, olfactory, or gustatory. Most commonly, hallucinations occur in the presence of a functional psychiatric disorder such a schizophrenia or an affective disorder. They may also occur in the presence of a global organic brain syndrome such as delirium (see below) or dementia. Occasionally, hallucinations occur in the absence of a functional or another organic disorder, in which case the diagnosis of organic hallucinosis is made (Table VII.)

TABLE VII Diagnostic Criteria for Organic Hallucinosis

A. Persistent or recurrent hallucinations are the predominant clinical feature.
B. No clouding of consciousness as in delirium; no significant loss of intellectual abilities as in dementia; no predominant disturbance of mood as in organic affective syndrome; no predominant delusions as in organic delusional syndrome.
C. Evidence from the history, physical examination, or laboratory tests of a specific organic factor that is judged to be etiologically related to the disturbance.

Any kind of hallucination may be the result of organic hallucinosis, but auditory hallucinations are more likely to be functional than organic, and visual, gustatory, olfactory, and tactile hallucinations are more likely to be organic than functional. From a forensic perspective, the most important determination is whether the hallucinations are malingered. Some of the characteristics which distinguish true from malingered hallucinations are summarized in Table VIII. Malingered hallucinations tend to be more detailed, bizarre, fantastic, and complex. Malingered hallucinations are more likely to be sudden in onset; functional hallucinations tend to appear gradually, often at first in an indistinct form and only becoming more distinct after a period of time. Malingered hallucinations tend to be continuous, that is, subjects will report that the hallucinations do not get better under any circumstances. Functional hallucinations often wax and wane throughout the day and patients often report that they can do certain things either to cause the hallucinations to disappear or to make them less bothersome. Malingered hallucinations are often unaccompanied by the appropriate emotions such as fear or bewilderment, and are often unaccompanied by associated delusions. Functional hallucinations can be quite frightening to the patient and are often accompanied by delusions such as ideas of persecution. A patient malingering hallucinations is usually quite willing to discuss them and may even offer them for discussion spontaneously: "doc, did I tell you I was hearing voices?" Patients with functional hallucinations usually do not mention them at all until they are asked specifically and even then may be reluctant to discuss them. The presence of an antisocial personality disorder, a previous history of malingering, and obvious secondary gain should alert the examiner to the presence of malingered hallucinations. Furthermore, the absence of symptoms usually associated with a chronic mental disorder should raise the examiner's index of suspicion that the hallucinations are malingered. These symptoms include flat affect, thought disorder, difficulties concentrating, inertia, and poor interpersonal relations.

The most common cause of organic hallucinosis is substance abuse, par-

TABLE VIII Differentiating True from Malingered Hallucinations

	True	Malingered
Complexity	Voices conversing, simple images	Fantastic, bizarre, complex involving multiple senses
Onset	Gradual, evolving from indistinct, vague to fully formed	Sudden onset of fully formed hallucinations
Stability	Wax and wane; patient has control over their intrusiveness	Continuous, nothing makes them better
Accompanying Affect	Fear, anxiety, bewilderment	Lack of appropriate affect
Delusions	Common	Less common

ticularly by hallucinogens such as LSD and phencyclidine. In alcohol hallucinosis, the hallucinations usually consists of voices or unformed sounds such as buzzing or hissing. Their onset is within the first 48 hours after cessation of drinking, and are accompanied by other signs of alcohol withdrawal, such as sweating, insomnia, tremulousness and increased pulse and blood pressure. They usually occur in an individual who has abused alcohol for many years. Their duration is typically less than a week, but approximately 10% of patients develop chronic hallucinosis. Other common causes of organic hallucinosis include temporal lobe epilepsy and sensory deprivation.

ORGANIC AFFECTIVE DISORDER

Case Three

A 60-year-old male attorney with no previous history of psychiatric disorder was referred by his employer to determine his fitness to return to work. He had no history of criminal behavior and was performing adequately in his job until six days prior to the evaluation. At that time, a complaint was filed against him for making sexual comments about a female co-worker. Over several days, he became irritable, shouted angrily at his clients, and appeared to have difficulty concentrating on his work. His thinking was described as disorganized. On the day of the evaluation he had gotten into an altercation with co-workers and was brought to the emergency room for evaluation.

On arrival he was unshaven and disheveled, despite wearing an expensive suit. He protested furiously at being evaluated. His speech was rapid, difficult to interrupt, and changed quickly from one topic to another. He paced throughout the interview. He denied hallucinations but admitted to ideas of reference and persecution, saying his employer was jealous of his knowledge and experience and wanted to discredit him. A call to his family physician revealed that he had begun taking the steroid medication Prednisone two weeks prior, to treat an exacerbation of an intestinal disorder. The physician was concerned that the patient might be taking it excessively; the patient had told him that he had "never felt better" shortly after starting the Prednisone.

The family physician convinced the patient to enter the hospital where, after tapering the Prednisone and initiating low dose antipsychotic treatment, the patient returned to his baseline state: genial, considerate, and without any sign of mania or depression.

This is an example of an organic affective syndrome, caused by a prescription medication Prednisone. The diagnostic criteria for this syndrome are shown in Table IX.

TABLE IX Diagnostic Criteria for Organic Affective Syndrome

A. The predominant disturbance is a disturbance in mood, with at least two of the associated symptoms listed in criterion B for manic or major depressive episode.
B. No clouding of consciousness as in delirium; no significant loss of intellectual abilities as in dementia; no predominant delusions or hallucinations, as in organic delusional syndrome or organic hallucinosis.
C. Evidence from the history, physical examination, or laboratory tests of a specific organic factor that is judged to be etiologically related to the disturbance.

The primary disturbance in an organic affective disorder is a change in mood. In the manic form, the mood becomes euphoric, expansive, or irritable. Associated symptoms may include an increase in activity or restlessness, increased talkativeness, flight of ideas, generosity, a decreased need for sleep, distractibility, and involvement in potentially harmful activities such as sexual indiscretion, buying sprees, and reckless driving. In the depressed form of the organic affective syndrome, there is either a depressed mood or a pervasive loss of pleasure in almost all aspects of living. Associated symptoms may include a change in appetite or sleep patterns, an increase or decrease in physical activity, a loss of interest in activities or sexual drive, fatigue, feelings of worthlessness or guilt, an inability to concentrate, and suicidal thoughts. In both the manic and depressed forms, psychotic symptoms such as hallucinations or delusions may be present.

Organic affective syndrome is most commonly due to a side effect of a medication, such as steroids (Prednisone), antihypertensives (propranolol, methyldopa, reserpine), disulfiram (Antabuse), levo-dopa, cimetidine (Tagamet), and tricyclic antidepressants (Medical Letter, 1986). Endocrine disorders, especially disorders of the thyroid, parathyroid, and adrenal glands are commonly associated with changes in mood. Strokes to the left frontal lobe of the brain, pancreatic tumors, withdrawal from a stimulant such as amphetamine or cocaine, head trauma and infectious processes as tertiary syphilis, influenza, and mononucleosis are other causes of organic affective syndrome (Krauthammer & Klerman, 1978).

While anyone presenting with a mood disorder deserves a careful examination to rule out organic causes, an even higher index of suspicion is warranted for the older patient who has no previous history of affective disorder. Parts of the evaluation deserving particular attention are a careful review of all medications, including those purchased over-the-counter, a urine drug screen, and tests of endocrine functioning including thyroid and adrenal function tests.

ORGANIC DELUSIONAL SYNDROME

Delusions are fixed, false beliefs that are not part of one's culture. Examples of delusions include ideas of reference and persecution (that one is the object

...by the FBI, that one is being poisoned by family members), delusions of grandiosity (that one is especially gifted, talented, or possesses special powers) and delusions of control (that one's thoughts, feelings, and actions are being controlled by others). They may be found in functional disorders such as schizophrenia and affective disorders, and in other organic disorders such as dementia or delirium. In some cases, delusions may be an isolated feature of an organic brain syndrome (Table X).

TABLE X Diagnostic Criteria for Organic Delusional Syndrome

A. Delusions are the predominant clinical feature.
B. There is no clouding of consciousness as in delirium; there is no significant loss of intellectual abilities as in dementia; there are no prominent hallucinations as in organic hallucinosis.
C. There is evidence from the history, physical examination or laboratory tests of a specific organic factor that is judged to be etiologically related to the disturbance.

Case Four

In 1800, 43 years before McNaughton, James Hadfield fired a pistol at King George III as the king entered his royal box at the theater. Hadfield had been well until 1794 when he was wounded during the French Revolutionary wars, receiving two sword blows to the head penetrating the skull to the brain. On recovery, he developed the belief that he was King George, and would stand staring into a mirror, looking for his crown. Later he believed himself to be God or Christ, and thought that only his martyrdom could save the world from disaster. Because suicide was a sin, he conceived a plan where he would shoot at, but miss the king, in the hope that he would be executed.

During his trial, his attorney, Thomas Erskine, argued for the acceptance of partial insanity, as manifested by Hadfield's delusions, as exculpatory. After a dozen witnesses testified to Hadfield's unfortunate history, the Chief Justice stopped the proceeding and the jury was advised to enter a verdict of not guilty by reason of insanity (Maeder, 1985).

The most common type of organic delusional syndrome is a paranoid state marked by suspiciousness, tenseness, hypervigilance, pathological jealousy and/or ideas of reference, and persecution. Substance use, particularly of amphetamines, cocaine, or hallucinogens is a common etiology and is often accompanied by an underlying personality disorder having paranoid traits. Chronic alcoholism, Vitamin B12 deficiency, temporal lobe epilepsy, hyperparathyroidism and temporal lobe epilepsy have all been associated with organic delusional disorder.

DELIRIUM

The final organic brain syndrome to be considered is delirium, a complication of many medical disorders, affecting 10%–40% of hospitalized patients. Delirium is distinguished from the syndromes already discussed by the presence of "clouding of consciousness," a term which signifies a state in which one's appreciation of the environment is altered, and in which one's attention span is diminished. The altered awareness of the environment may be manifested by drowsiness, by hyperalertness in which minor stimuli (such as the sound of air coming through air ducts) are not screened out, or by misperceptions (hearing a door bang shut and believing it to be a gunshot). A diminished attention span is manifested by an inability to maintain a string of thoughts and an inability to sustain mental concentration, such as that required to memorize and repeat a list of numbers. Associated symptoms include hallucinations, delusions, disorientation, altered sleep pattern, and incoherent speech (Table XI for diagnostic criteria for delirium). The onset of delirium may be abrupt, over several hours or several days, and its course tends to wax and wane. Psychotic symptoms may be so vivid as to severely impair the patient's judgment—delirious patients have been known to jump out of hospital windows, pull out catheters and intravenous lines, and become combative towards staff and family.

TABLE XI. Diagnostic Criteria for Delirium

A. Clouding of consciousness (reduced clarity of awareness of the environment) with reduced capacity to shift, focus, and sustain attention to environmental stimuli.
B. At least two of the following: (1) perceptual disturbance, misinterpretations, illusions, or hallucinations; (2) speech that is at times incoherent; 3) disturbance of sleep—wakefulness cycle with insomnia or daytime drowsiness; 4) increased or decreased psychomotor activity.
C. Disorientation and memory impairment (if testable).
D. Clinical features that develop over a short period of time (usually hours to days) and tend to fluctuate over the course of a day.
E. Evidence from history, physical examination or laboratory tests of a specific organic factor that is judged to be etiologically related to the disturbance.

Delirious patients are not usually seen in the outpatient setting, because they are usually so ill physically as to require hospitalization. The most common reasons for forensic evaluations in these patients involve determination of competence to consent to or refuse treatment and competence to sign out of the hospital against medical advice. However, even in these cases, forensic consultation is often not obtained, as either the patient's condition is so serious as to require the medical staff to begin treatment immediately or because the delirium goes unrecognized.

Case Five

A 54-year-old man, hospitalized with a complaint of stomach pain became irritable with the nursing staff on the night following his admission. He complained that medications weren't being delivered promptly and that "since nothing is being done for me, I might as well as go home." He demanded to leave the hospital and the medical resident on call was notified. After examining him briefly, the medical resident allowed the patient to sign out of the hospital against medical advice.

Within several hours, the hospital was notified that police had found the patient lying at the bottom of a dry swimming pool located nearby. He had apparently fallen into the pool accidentally. He was returned to the hospital where it was learned he had fractured a leg and an arm in the fall. On examination by the psychiatric consultant, he was found to be agitated, easily distractible, spoke in a rambling manner, and had hyperactive tendon reflexes elevated blood pressure and pulse, and was tremulous and sweating. A telephone conversation with his wife revealed that he had been a heavy drinker for many years, and had been "out of his mind" several times previously when he had stopped drinking suddenly. A diagnosis of alcohol withdrawal delirium was made after other causes of delirium were ruled out.

This case illustrates how easily delirium may be overlooked, especially in the absence of prominent delusions or hallucinations. However, because thought processes are so disorganized during delirium, patients may not be able to exercise proper judgment with respect to many areas of their life including medical treatment.

In evaluating the delirious patient the emphasis is on a search for offending substances, either prescribed medication, illicit drugs, or substances such as alcohol which are associated with delirium. The list of the medications reported to cause delirium is very large; some of the more frequent ones include steroids, analgesics (especially opiates), antiarrythmics (e.g., lidocaine), cimetidine, levo-dopa, and antidepressants (Medical Letter, 1986). Many drugs taken without adverse consequences by millions of people, may produce a toxic delirious reaction in a patient predisposed by age or by previous injury to the brain (as in chronic alcoholism). Similarly, a minor infection or metabolic derangement may produce delirium in a predisposed patient. Because the presence of delirium often heralds a potentially serious medical illness or complication, every effort must be made to determine the etiology. In addition, most cases of delirium can be quickly reversed once recognized. If there is a question as to whether delirium exists, an electroencephalogram may be helpful; almost all delirium is associated with an abnormal EEG (Lipowski, 1980).

Conclusion

Organic brain syndromes are important in forensic behavioral sciences for several reasons. First, patients with organic brain syndromes often come to the attention of the legal system. There may be questions about competence, such as to make a will, to consent to or to refuse medical treatment, to manage financial affairs, or to stand trial. There may be a question about criminal responsibility; was a particular criminal behavior related to the presence of delusions, hallucinations or mood changes, any of which may have had an organic etiology? Second, from a treatment perspective, an organic brain syndrome signals the presence of an underlying physical illness. Often these illnesses are highly treatable; in these cases the psychiatric prognosis is very good, much better than if the syndrome had been treated as a functional disorder. Finally, and especially important in the forensic setting, patients may malinger mental illness, the most common example being malingered amnesia. Familiarity with the clinical characteristics of the particular organic brain syndrome makes it much more likely that the malingering will be detected.

When should a patient be evaluated for an organic brain syndrome? Although it is not practical to give all patients the most extensive organic evaluation, every patient should receive at least minimal screening: a medical history, physical examination, basic blood work, and, in the forensic setting, a urine drug screen. The most complete organic evaluation should be reserved for special cases. For example, a patient over 40 years of age who presents with antisocial behavior of recent onset should be evaluated more thoroughly, from an organic perspective, than a 22-year-old man with longstanding psychopathic traits. Other patients for whom there is an increased index of suspicion for an organic brain syndrome include elderly patients, patients with a long history of drug and/or alcohol abuse, and patients with a history of trauma to the head.

Even in the absence of predisposing factors, there are circumstances in which a vigorous evaluation may be pursued in an attempt to uncover biological data. "Hard" data such as a CT scan or an electroencephalographic tracing, which show "something wrong" with the brain, may be more persuasive in a courtroom than "soft" psychological explanations. Especially in high profile cases where expense is relatively less important, organic data are vigorously searched for, even in the absence of clinical findings which would suggest an organic brain syndrome. Thus, a scan of the brain done on would-be presidential assassin John Hinckley, showing enlarged ventricles, may have helped to persuade the jury that he indeed did have "something wrong" with his brain. They found him not guilty by reason of insanity.

Finally, organic brain syndromes are important in helping us to understand the relationship between mind and brain. Studies which show an association between specific lesions in the brain and corresponding defects in aspects of mental functioning, e.g., speech or memory, are invaluable in furthering our knowledge in the neurosciences. Rather than finding, as Eckstein (1970) said,

that "no modern surgeon enters the skull to find mind," perhaps it is more the case that no modern psychiatrist enters the mind without finding brain.

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Menstruation and Crime: A Critical Review of the Literature from the Clinical Criminology Perspective

Bruce Harry, M.D
Charlotte M Balcer, M.D.

The authors review the literature on the relationship between menstruation and crime, focusing upon the methodological limitations of these studies in the broader context of criminological and menstruation research. Based on this review, they conclude: the present state of scientific knowledge is such that it is unknown whether there is an association between any phases of the menstrual cycle and crime; there is no evidence linking fluctuations in reproductive hormones to criminal behavior; and, this lack of scientific knowledge is so glaring that evidence regarding menstruation and crime should not be admissible in criminal trials.

INTRODUCTION

The relationship between menstruation and crime has been a focus of scholarly interest for at least a century In his review of women and crime, Pollak (1950) cited several late nineteenth and early twentieth century European observations that reported an ostensibly positive association between the menstrual flow and a variety of antisocial/criminal behavior such as resistance against public officials, shoplifting, thefts, arson, and homicide (Icard, 1890, Aubry, 1891; Lombroso and Ferrero, 1894; Krafft-Ebing, 1902; Gross, 1905, Gudden, 1907; Marx, 1908; Boas, 1909, von Hentig, 1930).

Among early English language writers, both Healy (1915) and Burt (1925) thought menstruation amplified underlying emotional instabilities, with the premenstrual phase perhaps being the time of greatest instability. However,

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APPENDIX "C"

Profile and Case Summary

The Minnesota Multiphasic Personality Inventory

Starke R. Hathaway and J. Charnley McKinley

Scorer's Initials _____

Name Wilstead, Errol | M Male

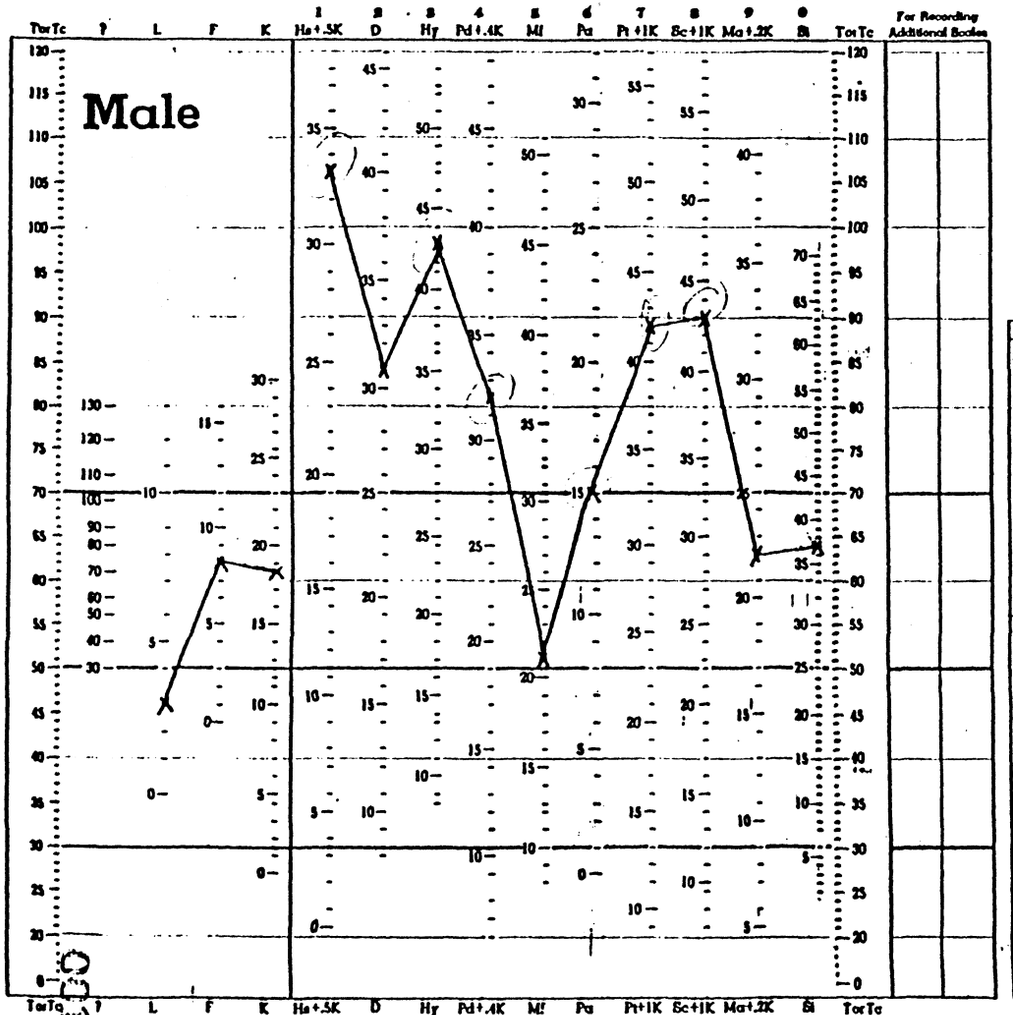
Address _____

Occupation _____ Date Tested 3-13-87

Education _____ Age 34

Marital Status _____ Referred by _____

NOTES



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	1	2	3	4	5	6	7	8	9	0				
Raw Score	21	3	8	18	24	31	43	25	21	15	34	35	18	37
K to be added					9			7			18	18	4	
Raw Score with K					33			32			42	43	22	

Signature _____ Date _____

Copy 1-23-89

Profile and Case Summary

The Minnesota Multiphasic Personality Inventory

Starke R. Hathaway and J. Charnley McKinley

Name Wiltead, Errol 2-23-89 M

Address _____ Male

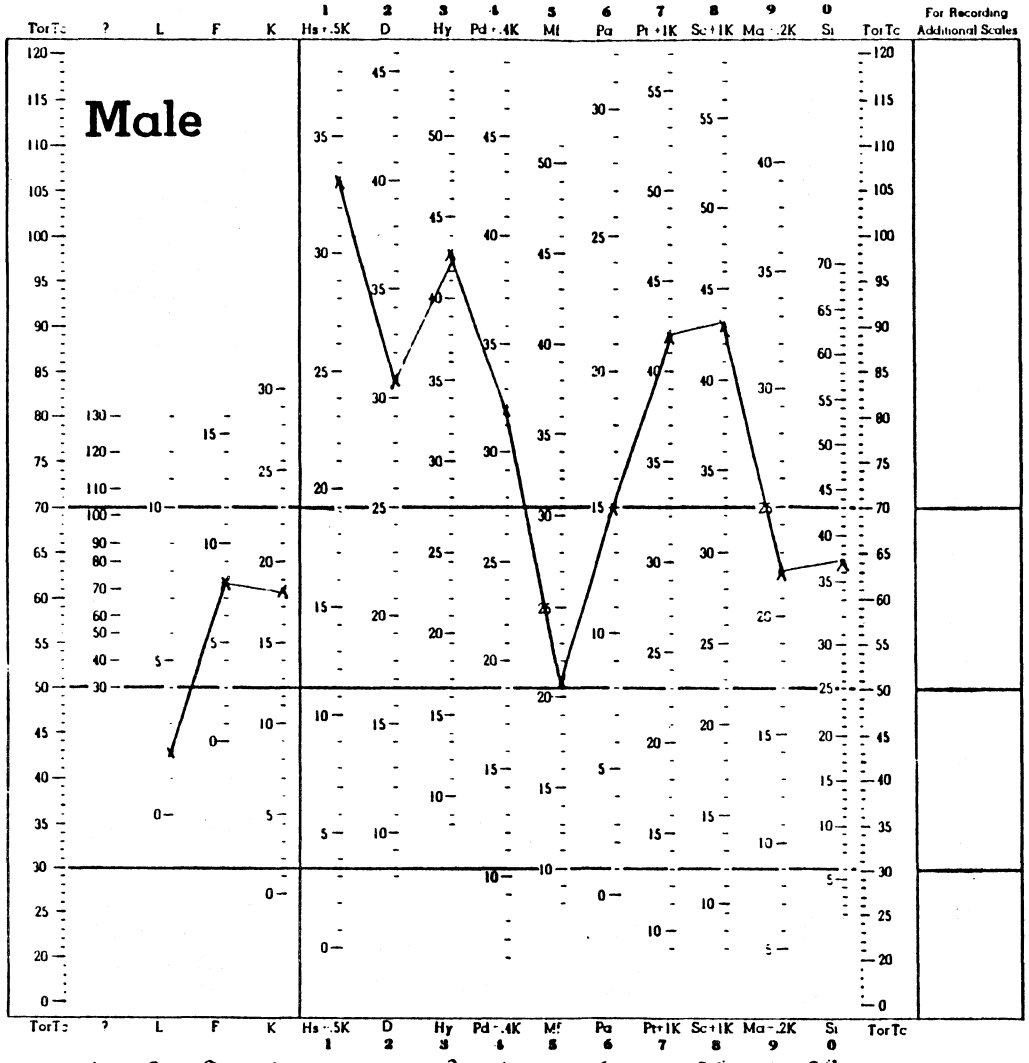
Occupation _____ Date Tested 3-13-89

Education _____ Age 34

Marital Status _____ Referred by _____

NOTES

Scorer's Initials _____



	TorTc	?	L	F	K	Hs+.5K	D	Hy	Pd+.4K	Mf	Pa	Pt+1K	Sc+1K	Ma+.2K	Si	TorTc
		1				2	3	4	5	6	7	8	9	0		
Raw Score		1	3	8	18	24	31	43	25	21	15	34	35	18	37	
K to be added						9			7			18	18	7		
Raw Score with K						33			32			52	53	25		

K	1	.4	.2
30	15	12	6
29	15	12	6
28	14	11	6
27	14	11	5
26	13	10	5
25	13	10	5
24	12	10	5
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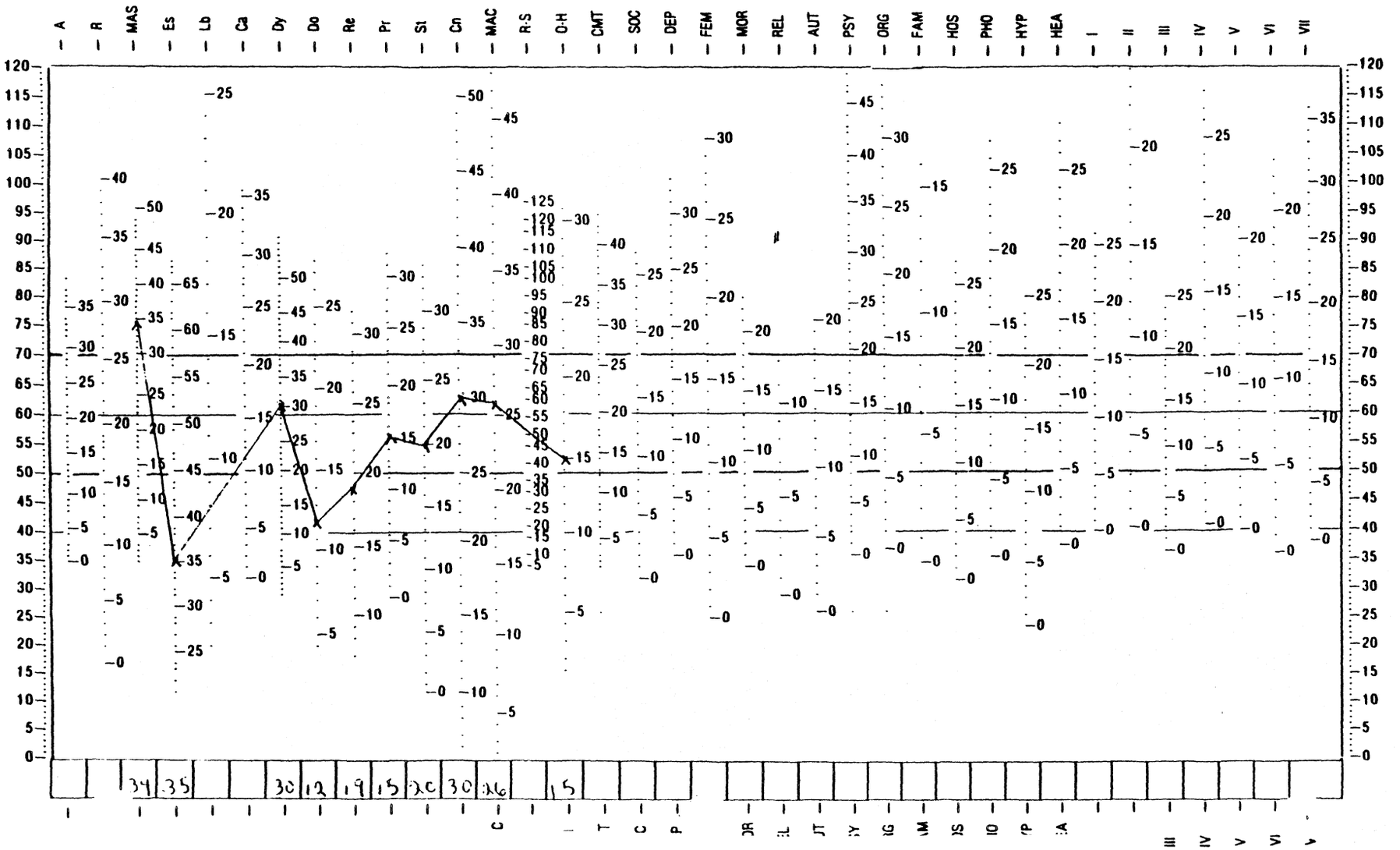
MMPI PROFILE SHEET: MALE

FREQUENTLY SCORED RESEARCH, WIGGINS CONTENT AND TRYON, STEIN & CHU SCALES

NAME Wilstead, Errol AGE 45 DATE TESTED 3/13/87

ADDITIONAL INFORMATION



APPENDIX "D"

coal mine and after --

Q So there was an injury while you were employed at Peabody?

A January the 16th, 1975.

Q Okay.

A At 4:10 p.m.

Q Okay. And what type of back injury did you sustain at that point?

THE COURT: We needn't go through all of that. That's already been litigated, counsel.

THE WITNESS: Fracture of T-10, I was told.

MR. TREASE: Okay.

Q (By MR. TREASE) Okay. And did you receive an impairment rating at that point?

A I don't know.

THE COURT: That's all in the file.

MR. TREASE: Okay.

Q As far as that injury, you left their employment. Who was it that you were next employed by? Were you employed by another coal mining operation?

A Yes.

Q Was that coal mining operation under the name of Hiawatha?

A Yes. U.S. Fuel Company Hiawatha.

Q Okay. During what time period were you

Q Okay. And it shifted or it fell out?

A Tipped over, due to air slack, you know. That was about four foot thick, seven to eight feet high and sixty feet long.

MR. BOORMAN: Can he date that injury?

Q (By MR. TREASE) What was the date of that injury?

THE COURT: What, Mr. Boorman?

MR. BOORMAN: I was just wondering when the date -- when that injury was.

THE COURT: Was that the December injury?

Q (By MR. TREASE) Did that occur in December of 1981?

THE COURT: It should have been '79.

THE WITNESS: No, it was --

MR. DYER: October 24th according to the Findings of Fact of the prior litigation.

THE COURT: The October '79 injury? And then there was a December '79 injury too.

MR. DYER: Well, and an August '79 injury too. There are three of them listed.

THE COURT: Right. Can't we just consult the file on those, counsel?

MR. TREASE: Yes.

THE COURT: Those were all previously

MR. BOORMAN: Your Honor, if that doesn't show up in the medical records, then he is not qualified to answer it.

THE COURT: Sustained.

MR. TREASE: Okay.

THE COURT: The records speak for themselves, counsel.

MR. TREASE: Okay.

Q So do you believe now that you did actually fall on the Northwest yard?

A I don't know.

Q You do not have a belief one way or the other?

A I have a mental picture in my mind that I did, but I can't say, under oath, that I did fall in the Northwest yard.

Q Do you believe you fell?

A It's very possible.

Q Okay.

A I have a mental picture in my mind.

Q Following that fall or that flashback scenario, you weighed the truck. Is that correct?

A Yes.

Q And from that point, you left --

A I went over to the Roadrunner Truck Stop to

A He suggested that I go on to Blythe and go the hospital there, which was approximately twenty-six miles away.

Q Did you heed his advice and go to Blythe?

A Yes.

Q Did you seek medical attention at Blythe?

A Yes.

Q Do you recall who it was that attended you at Blythe?

A The name I don't remember. He was a negro fellow. He was an intern or a student out of --

Q Medically educated though?

A Huh?

Q Was he medically educated?

A Yes. He was the doctor in charge of emergency room at the Blythe Hospital.

Q Okay. The records reflect --

A I was in the emergency room all day long.

Q The records reflect that you, at that point, underwent x-rays of some type. Is that correct?

A He took an x-ray of my back, yes.

Q What did that x-ray portray?

MR. BOORMAN: I think they'll speak for themselves.

THE COURT: That's true. You needn't answer

A The doctor told me that the blow to the back of the head has caused a tremendous chemical imbalance of the --

MR. BOORMAN: Your Honor, I think --

Q (By MR. TREASE) Which doctor is that?

MR. BOORMAN: -- whatever reports will speak for themselves.

THE WITNESS: Dr. Bushnell.

Q (By MR. TREASE) Okay.

A And Dr. Kotrady. Both.

Q Okay. When was the last time that you drove truck?

A February the 17th, -- No. Yeah, I think February -- Yeah, February the 17th, when I got home, 1987.

Q And why was it that you had not driven the truck since that time?

A I can't -- I can't safely drive a vehicle -- a truck down the road and maintain proper lane control and judgment and --

Q Is that your personal opinion, or has somebody else told you?

A Highway patrolman.

Q Okay. Was there anybody from the medical profession that has told you not to drive truck?